PATIENT INFORMATION

Patient Name: ____
First M.I. Last

Address ____

City ______________________________ State__________ Zip__________

Home Phone ( ) ______________________ Work Phone ( )______________

Cell Phone ( ) ______________________

Sex: Male Female Date of Birth ____/____/____ Marital Status: Single, Married, Divorced, Widowed, Separated

Patient Social Security # ______________________

Do you have immediate family members who are patients here? ______________________

Place of Employment ______________________ Job ______________________

Employer address ____

If married,

Spouse Name ______________________ Spouse Date of Birth ______________________

Spouse Employer ______________________ Address ______________________

If minor,

Parent(s) Name ______________________ & ______________________

Address if different than patient

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____

Phone if different than patient

( ) ______________________ ( ) ______________________

Parent employer ______________________ ______________________

Parent work phone ( ) ______________________ ( ) ______________________

Person responsible for account: ______________ Relationship to patient ______________

INSURANCE (Please allow office staff to copy your insurance card)

Primary Insurance Company ____

Policyholder Name ______________________ Date of birth __________ SS# ______________

Secondary Insurance Company ____

Policyholder Name ______________________ Date of birth __________ SS# ______________

EMERGENCY CONTACT: ____

Phone # ______________________ Relationship ______________________

RELEASE AND ASSIGNMENT

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physician. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

X ____ Date ______________________

Patient Signature (or parent, if minor)

NOTICE: MEDICARE will not pay for routine foot care or orthotics (arch supports). Services that may be covered are: ingrown toenails, severe fungus or bacterial infection, abscess under corns or calluses, or routine foot care if you have peripheral vascular disease and/or another disease.