CENTER FOR PODIATRIC MEDICINE
Welcome To Our Office
Patient Information (PLEASE PRINT)

Date_____
Name _____ Age____ Date of Birth_____ Sex_____
Height_____ Weight_____ Shoe Size_____ Marital Status_____ Last 4 digits SS#_____
Address_____ Apt #_____ City/State_____ Zip Code_____
Home Phone_____ Work Phone_____ Cell Phone_____
Employer_____ Occupation_____
Employer Address_____ Email_____
How did you hear about our office? _____

PLEASE PROVIDE COPY OF ALL INSURANCE CARDS

Primary Insurance Name _____ ID# _____
Insured Name_____Date of Birth_____ Grp# _____
Secondary Insurance Name _____ ID# _____
Insured Name_____ Date of Birth_____

Emergency Contact_____Relationship_____ Telephone #_____

Primary Care Physician_____ Telephone # _____
Address_____ Last Seen_____

Former Podiatrist_____ Last Seen_____

List Medications You Are Taking_____
List Allergies to Medicine_____ Other Allergies_____
List any operations or serious illnesses? _____

Please check if you have or ever had any of the following:
___Diabetes __Aids (HIV) __Asthma __Epilepsy __Varicose Veins __High Blood Pressure __Heart Disease __Tumors
__Stomach Ulcers __Arthritis/Rheumatism __Liver Problems __Cancer __Migraine Headaches __Hepatitis
__Leg Cramps __Bursitis __Glaucoma __Kidney Problems __Anemia __Bleeding Tendencies __Blood Clots
Please circle - Are you a smoker? Yes or No Female only: Are you pregnant? Yes or No

******REASON FOR VISIT (FOOT COMPLAINT): _____**

*I hereby give my permission to the physician of Center for Podiatric Medicine to administer any treatment that may be necessary to treat my foot condition.
***I understand that I am financially responsible for all charges (whether or not covered by the insurance company).**
*I understand that if I receive a check from my insurance company for services provided by Center for Podiatric Medicine, I am responsible for payment immediately.
*There will be a $25 fee if you do not give 24 hours notice when cancelling your appointment.
*I understand that the Center for Podiatric Medicine is **NOT RESPONSIBLE** for any misquoted benefits by my insurance carrier.
*Phone calls to and/or from the office may be recorded and added as part of your medical record.
***COPAYMENTS MUST BE PAID AT THE TIME OF SERVICE**.

(*NOTE: PATIENT IS RESPONSIBLE FOR VERIFYING INSURANCE COVERAGE FOR ALL SERVICES.*)

AUTHORIZATION
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM.
I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO CENTER FOR PODIATRIC MEDICINE.

_____ _____

Signature Patient/ Parent or Guardian if Minor **Date**