CENTER FOR PODIATRIC MEDICINE

Welcome To Our Office Patient Information (PLEASE PRINT)

Date						
Name		Age	_ Date of Birth	Sex		
Height Weight Sh	oe Size	Marital Status_	Last 4 di	gits SS#		
Address		Apt #	City/State	Zip Code		
Home Phone		Work Phone		Cell Phone		
Employer			Occupation			
Employer Address		Email				
How did you hear about our o	ffice?					
PLEASE PROVIDE COPY OF	FALL INS	URANCE CARDS				
Primary Insurance Name		ID# Date of Birth Grp#				
Insured Name		Date of 1	Birth	Grp#		
Secondary Insurance Name _			ID#			
Insured Name			Date or	f Birth		
Emergency Contact		Relati	onship	Telephone #		
Primary Care Physician			Telepl	none #		
		Last Seen_				
Former Podiatrist	mer Podiatrist			Last Seen		
List Medications You Are Ta	king					
List Allergies to Medicine	8		Ot	ther Allergies		
List any operations or seriou	ıs illnesses	?				
Please check if you have or evDiabetesAids (HIV)AStomach UlcersArthritis/Leg CrampsBursitisG Please circle - Are you a so ****REASON FOR VISIT (sthmaĔ Rheumatis laucoma moker? Ye	pilepsyVaricose V mLiver Problems Kidney Problems s or No	s_Cancer_Migra Anemia _Bleeding Female only: Are	g TendenciesBlood Clots you pregnant? Yes or No		
				ny treatment that may be necessary to tr		
my foot condition.						

(*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.

^{*}I understand that I am financially responsible for all charges (whether or not covered by the insurance company).

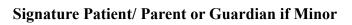
^{*}I understand that if I receive a check from my insurance company for services provided by Center for Podiatric Medicine, I am responsible for payment immediately.

^{*}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.



Date