Dr. Scott L. Cooper

NAME: _____ **DATE of BIRTH:** _____

ADDRESS: _____ APT #: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ GENDER: ___M ___F STATUS: __S __M __W __D __Other

CELL PHONE: _____ EMAIL: _____

SOCIAL SECURITY #: _____

REFERRED BY: _____

EMERGENCY CONTACT: _____ **TEL#:** _____

PRIMARY CARE PHYSICIAN: _____ **TEL#:** _____

EMPLOYER: _____ **TEL #:** _____

ADDRESS: _____ STATUS: __F/T __P/T __RET

PRIMARY INSURANCE: _____ **TEL#:** _____

ADDRESS: _____

POLICY HOLDER: _____ DATE of BIRTH: _____

POLICY HOLDER'S EMPLOYER: _____ TEL#: _____

PATIENT RELATIONSHIP: ___self ___spouse ___child ___other GROUP #: _____

POLICY #: _____ CO-PAY AMOUNT: _____

SECONDARY INSURANCE: _____ **TEL#:** _____

ADDRESS: _____

POLICY HOLDER: _____ DATE of BIRTH: _____

POLICY HOLDER'S EMPLOYER: _____ TEL#: _____

PATIENT RELATIONSHIP: ___self ___spouse ___child ___other GROUP #: _____

POLICY #: _____ CO-PAY AMOUNT: _____

RELEASE & ASSIGNMENT: I, the undersigned, authorize the release of any medical information necessary for claim submission and securing of benefits for all services rendered by my provider on behalf of myself and /or my dependents. Where my provider is participating with my insurance plan, I hereby assign payment for all services rendered directly to Dr. Scott L. Cooper. I understand that I will remain directly responsible for payment of any deductibles, co-insurances, and non-covered services.

SIGNATURE of PATIENT: _____ **DATE:** _____

CURRENT MEDICAL CONDITIONS:

( ) hypertension	( ) rheumatic disease	( ) bleeding disorders	( ) seizures
( ) kidney disease	( ) asthma/bronchitis	( ) ulcer/hiatal hernia	( ) stroke
( ) diabetes	( ) emphysema	( ) nervous condition	( ) gout
( ) heart disease	( ) arthritis	( ) other:	

CURRENT MEDICATION: _____

_____

_____

ALLERGIES: ( ) penicillin ( ) sulfa ( ) aspirin ( ) iodine ( ) tape ( ) other:_____

PREVIOUS SURGERY: _____

_____

PERSONAL HABITS: ( ) tobacco ( ) alcohol ( ) caffeine ( ) other:_____

CURRENT FOOT PROBLEM: _____

_____

_____