Progressive Podiatry PLLC

Patient Information- Please Print

Name: Last: _____ First_____ Middle: _____

Street Address: _____ Apt #:_____

City: _____ State: _____ Zip Code: _____

Home # _____ Cell Phone: _____

E-Mail Address (optional): _____

Social Security # _____ Date Of Birth: _____

Sex: _____ Allergies: _____

Contact in Case Of Emergency: _____ Phone# _____

Name of PCP or Primary Medical Doctor (this information must be provided, some insurance will not pay claim unless provided: _____

Doctor's Address: _____

Doctor's Phone # _____

Insurance Information:

Name of Primary Insurance: _____ ID # _____

Name of Insured _____ Relation _____

Insured's Name/ Date of Birth and Social Security # (must be provided if not self)

Please note there is a $75.00 charge for all missed (no show) and or appointments cancelled in less than a 24 hour period.

I authorize *Progressive Podiatry PLLC* to furnish information to my insurance carrier(s) concerning my illness and treatments and assign payment of benefits directly to them. I understand that I am responsible for any amount not covered by insurance. I further understand that any non covered service is my financial responsibility.

_____ _____

Signature **Date**