Robert J. Landy, DPM

Triple i / CliniForms

Patient Registration

Name _____ SS# _____

Street Address _____ Date of birth _____ Marital status: S M W Sep D

City _____ State _____ Zip _____

Telephone: Home _____ Office _____

Referred by _____

Spouse's name _____

Spouse's employer / address _____

Emergency contact _____ Tel# _____ Relationship _____

Patient Employer Information

Employer name _____ Tel# _____

Employer street address _____ City / State _____ Zip _____

Patients occupation _____

Insured Person (if not patient)

Name _____ Tel# _____

Street Address _____ City / State _____ Zip _____

Relationship to patient _____

Insurance

Medicaid # (if applicable) _____ Medicare # (if applicable) _____

Primary Insurance Company Name _____

ID # _____ Group # _____ Tel.# _____

Secondary Insurance Company Name _____

ID # _____ Group # _____ Tel.# _____

Medical Information Release and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date _____ Signature _____

I hereby authorize Dr. _____ to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to Dr. _____ (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date _____ Signature _____
(Patient, parent, or guardian)

Miscellaneous Notes

Name _____