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_____ Social Security #_____
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 _____
Insured Name_____ Date of Birth_____ Social Security #_____
Secondary Insurance Name _____
Insured Name_____ Date of Birth_____ Social Security #_____

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_____
Have you had 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 __Pneumatic Fever

CHIEF FOOT COMPLAINT: _____

*I hereby give my permission to the physician of Center for Podiatric Medicine to administer any non-surgical 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 paying you immediately.
*There will be a $25 fee if you do not give 24 hours notice when cancelling your appointment.
***COPAYMENTS MUST BE PAID AT THE TIME OF SERVICE.**

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

_____ _____
Signature **Date**

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 **Date**