FAMILY FOOT AND ANKLE CENTER OF SOUTH JERSEY
496 N. KINGS HIGHWAY
SUITE 210
CHERRY HILL, NJ 08034
PHONE (856) 667-8222 FAX (856) 667-9739

JOSEPH L. DIMENNA DPM, FACFAS
DAVID V. DIMENNA DPM, FACFAS
JOSEPH V. BAKANAS DPM

PATIENT INFORMATION FORM

NAME: ____
LAST FIRST MI

ADDRESS: ____________________ CITY: ______________ STATE: ______ ZIP: ________

PHONE (HOME): ______________ PHONE (WORK): ______________ PHONE (CELL): ______________

SS# ______________ MARITAL STATUS: __________RACE:________ AGE: ______ BIRTHDATE:__________

SHOE SIZE: __________ SEX: ________ HEIGHT: ________ WEIGHT: ________ BLOOD PRESSURE:________

GENDER IDENTITIY: __________ SEXUAL ORIENTATION ________________

OCCUPATION: ______________________ Email:______________________

EMERGENCY CONTACT NAME: ________________RELATIONSHIP ________ PHONE:____________

PRIMARY CARE OR REFERRING PHYSICIAN: ____________________ PHONE: ______________

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?: ______________________________

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE: ______________________________________

SECONDARY MEDICAL INSURANCE: ______________________________________

NAME OF INSURANCE SUBSCRIBER: ____________________ DATE OF BIRTH: ______________

IS THIS A WORK RELATED INJURY?: YES NO DATE OF INJURY: __________ EMPLOYER PHONE: ____________

EMPLOYER NAME AND ADDRESS: ______________________________________

____

ADJUSTER NAME: __________________ PHONE: ____________ DATE OF INJURY: ____________

CLAIM #: ________________ CLAIMS ADDRESS:______________________________

MOTOR VEHICLE ACCIDENT? (CIRCLE) YES NO DATE OF ACCIDENT: ____________ DRIVER/PASSENGER

OTHER:____

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for service rendered, or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents. I acknowledge that I will be bound by this signature as though the undersigned had personally signed the particular claim. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify that the information above is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

I ____________________ hereby authorize my insurance company to pay and assign all benefits directly to FAMILY FOOT AND ANKLE CENTER OF SOUTH JERSEY for services provided. I understand that I will be responsible for any co-payments, deductibles, non-covered or unauthorized services, or any services provided after my coverage ceases to be effective. I further acknowledge that any insurance benefits, when received by and paid to FAMILY FOOT AND ANKLE CENTER OF SOUTH JERSEY will be credited to my account, in accordance with the above assignment.

______________________________ ____________________
(Authorized signature of subscriber) **(Date)**