WELCOME TO OUR OFFICE

Name_____Age_____Date of Birth_____
Social Security #_____Sex_____Marital Status_____
Address_____
City_____State_____Zip_____
Home Phone( )_____Work Phone( )_____
Cell Phone ( )_____Occupation_____

Place of employment_____
Address_____
City_____State_____Zip_____
Name of Spouse, Parent, Guardian_____

Person responsible for payment (if different from patient)_____
Address (if different from patient)_____

Medical Insurance Company_____
ID #_____Group #_____
Insurer's name_____Copay$_____

In case of emergency, please contact _____
Phone ( )_____
Family Doctor_____Phone/City_____

How did you learn about this office?(Please Circle) PPO listing HMO referral Yellow pages
Family doctor referral Patient referral Coupon/Postcard Web search

Briefly describe your problem_____
Shoe size_____

By signing below I authorize the following:

1) The release of any medical information to process my insurance claim.
2) The payment of medical benefits to be paid directly to the physician.
3) That treatment can be performed such as general procedures as is deemed necessary in the diagnosis and treatment of my foot condition (permission to examine and treat)
4) I have received the Notice of Privacy Practices and have been given the opportunity to review it
5) Unpaid balances after 60 days will be charged up to 35% to collect these balances

_____Date_____
Signature of patient/guardian