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Surgeons ♦ Podiatrists

WELCOME TO OUR OFFICE

Please answer **ALL** questions to the best of your ability. This information is important for your health and our records. If you need more room for any of the questions, you may flip over to the backside to finish

(1) Mr. Mrs. Ms. Dr. (2) First _____ (3) Middle _____ (4) Last _____

(5) Mailing Address (Street, P.O. Box, Apt #) _____
 City: _____ State: _____, Zip: _____

(6) Physical Address (911 – if different from above) _____

(7) E-mail Address _____ (8) Phone #: (____) _____

(9) Cell Phone #: (____) _____ (10) Full Time Student or Part Time Student

(11) Date Of Birth: ___/___/___ (12) Sex – Male or Female (13) Social Security Number: _____

(14) Occupation: _____ (15) Employer Name _____

(16) Employer Address: _____
 City _____ State _____ Zip _____ (17) Work Phone #: (____) _____

(18) Person Responsible if Patient is a Minor: _____
 Address (if different from above): _____

Responsible Party Employer Name, Address and Phone #: _____

Social Security Number: _____ Phone #: (____) _____ DOB: _____

(19) Primary Care Physician **and** Phone Number: _____

(20) Emergency Contact Information: (Name, Relationship and Phone #)

(21) Current Insurance: _____ Subscriber: _____
 Is Subscriber: Male or Female Subscriber SS#: _____ Subscriber DOB: _____
 Subscriber Work #: _____ Subscriber Employer and Address: _____

(22) Secondary Insurance: _____ Subscriber: _____
 Is Subscriber: Male or Female Subscriber SS#: _____ Subscriber DOB: _____
 Subscriber Work #: _____ Subscriber Employer and Address: _____

(23) Is your Prescription Plan Different From Your Health Plan? Yes No If so, please give card to the receptionist to copy.

(24) If you are a patient with military insurance are you: Active Duty or Retired Military

PLEASE NOTE: PAYMENT IS EXPECTED IN FULL AT THE TIME OF SERVICE, unless insurance information or an insurance claim form is provided at the time of service. Also, upon visit you will be responsible for any co-pay/deductible/your percentage that has not been met at the time of service. Claims pending over (6) weeks will be your responsibility. Any payment received from your insurance company greater than your outstanding balance will be refunded to you or the insurance company. You are responsible for anything that is not covered by your insurance for today's visit. We bill insurances as a courtesy. If there is any information we request and feel is important for the billing process, (i.e. SSN, Physical address, etc.) and you are not willing to give this information to us you will be responsible for payment in full the date of service and to submit claim to your insurance company yourself. This also authorizes a credit report to be acquired by us if an account is to be established.

Signature _____

Date _____