



*Dr. Stephen M. Carley      Dr. Michael C. Donato      Dr. Martha A. Hurley*  
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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) Home Fax Number: (\_\_\_\_) \_\_\_\_\_

(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): \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Phone #: \_\_\_\_\_ DOB: \_\_\_\_\_

(19) Primary Care Physician **and** Phone Number: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

(21) Current Insurance: \_\_\_\_\_ Subscriber: \_\_\_\_\_

Subscriber SS#: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_ Subscriber Work #: \_\_\_\_\_

Subscriber Employer and Address: \_\_\_\_\_

(22) Secondary Insurance: \_\_\_\_\_ Subscriber: \_\_\_\_\_

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 receptionist for copying.

**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