Access Wound Care and Podiatry Care

New Patient Information Form

* Required fields

PATIENT INFORMATION

Name:*

Address:*

City:*

Zip:*

Phone number:*

Sex:* ◉ Male ○ Female

Birthdate:* mm/dd/yyyy

Marital status:* ◉ S ○ M ○ W ○ D

Patient SS#:*

Occupation:*

Employer:*

Employer phone:*

Spouse name:

In case of emergency contact:*

Phone:*

Relationship:*

Patient email:

FAMILY PHYSICIAN

Name:

Address:

Phone:

Date of last appointment: choose date

What is the chief complaint for which you wish to be treated?

Is this a work related injury? ◉ yes ○ no

Automobile injury? ◉ yes ○ no

Date of injury: choose date

Referred to our office by:

INSURANCE

Medicare:

Medi-Cal:

Issue date: choose date

Are you under an **HMO** plan? ◉ yes ○ no

Do you have an authorization form PCP? ◉ yes ○ no

Medicare Supplement Insurance:

Company:

Phone:

ID#:

Group:

Private Insurance:

Name of company:

Phone:

ID#:

Group:

Subscriber name:

DOB: choose date

Relationship to patient:

Is patient covered by other insurance?

Assignment and release:

I hereby give my permission to Dr. _____ or his associates to administer treatment as may be deemed necessary in the treatment and diagnosis of my foot and or ankle complaints. and I hereby authorize my insurance company to pay benefits directly to Dr. _____.
I understand that I am financially responsible for all non-covered services. I also authorize Dr. _____ to release any information required to bill the insurance company for me. I also authorize the use of this signature on all insurance submissions.

Responsible party:

Relationship:

Date: choose date

Medicare authorization:

I request that payment of authorized Medicare benefits be made on my behalf to Dr _____ for any services furnished me by the listed provider. I authorize any holder of medical information about me to release to the NHIC and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature below request that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA-1500 form. or elsewhere on other approved claim forms or electronically submitted claims. my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases. the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge. and the patient is responsible only for the deductible. co-insurance. and non-covered services. Co-insurance ant the deductible are based upon the charge determination of the Medicare carrier

Beneficiary name:

Date: choose date

As an anti-spam measure, type the random numbers displayed here.

_____ 9677

Submit Form