WELCOME TO OUR PRACTICE

PATIENT INFORMATION (PLEASE PRINT)

Name:_____

Address: _____

City: _____Zip:_____

Phone Number : _____

Sex: _____ Birthdate : _____

Marital Status: S_____ M_____ W_____ D_____

Patient SS#:_____

Occupation: _____

Employer: _____

Employer Phone: _____

Spouse Name: _____

In Case of emergency contact: _____

Phone: _____ Relationship: _____

FAMILY PHYSICIAN

Name: _____

Address: _____

Phone: _____

Last day seen: _____

What is the chief complaint for which you came to be treated today:

_____

_____

Is this a work related injury? _____

Automobile injury? _____

Date of Injury: _____

Referred to Our Office by:

_____

Patient email:

_____

INSURANCE

Medicare : _____

Medi-Cal: _____ _____
ISSUE DATE

Are you under an **HMO** plan? _____

Do you have an authorization form PCP? _____

Medicare Supplement Insurance:

Company: _____

Phone: _____

ID#: _____Group:_____

Private Insurance:

Name of Company:_____

Phone: _____

ID #: _____ Group: _____

Subscriber Name: _____

DOB: _____ Relationship to patient: _____

Is patient covered by another 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 Signature : _____

Relationship: _____ 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 signature Date

(800) 480-3338 Fax (818) 279-0545