PODIATRY GROUP, P.A. ~ NEW PATIENT INFORMATION

Name (Last)_______________________________(First)__________________________(MI)_____
Home Address ____ Apt. #________
City, State, Zip ____
Phone # Home____________________ Work____________________ Cell___________________
SS#______________________________ Age _______ Date of Birth ____/____/____ Sex M / F
Employer __________________________ FT PT Ret. N/A Occupation_______________________
Student Status FT PT N/A

Please list the Name, Phone # and Relationship of your emergency contact:

____

Whom may we thank for referring you? ____

PRIMARY INSURANCE:
Subscriber__________________________________ Relationship to patient__________________
Insurance Co.________________________________Subscriber date of birth_________________
Policy/Group #_______________________________ID#____________________________________
SECONDARY INSURANCE:
Subscriber__________________________________ Relationship to patient__________________
Insurance Co.________________________________Subscriber date of birth_________________
Policy/Group #_______________________________ID#____________________________________

Are any of your concerns today related to a workman's comp. case or an automobile accident? YES/NO

IMPORTANT If applicable, may we leave medical information on your home answering machine, voice mail or with a family member? (For example, appointment reminders, lab results, insurance coverage info., etc.?) **NO** ___ **YES** ___ If NO, please write the number we should use: ____________________

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet, ankles or lower legs. I hereby authorize medical information to be sent to my primary physician.

SIGNATURE ____DATE ______________

If signing for a minor, please list your relationship to patient: _________________________________

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