WE ARE VERY GLAD TO HAVE YOU WITH US

It is important for the doctors to have your personal information to care for your health.
If you need any help filling out this form, our podiatry assistant will be happy to assist you.

Please give the receptionist your insurance care so that she can make a copy of it for our records while you complete this form.

☐ Mr. ☐ Mrs.

NAME ____ ☐ Ms. ☐ Dr.
(Last) *(First)* *(Middle)*

ADDRESS ____
(Street) *(City)* *(State)* *(Zip)*

PHONE ____
(Home) *(Cell)* *(Business)*

Marital Status: Single ☐ Divorced ☐ Married ☐ Widowed ☐ Sex: Male ☐ Female ☐

DATE OF BIRTH ________________ SOC SEC________________________

EMAIL ADDRESS: ____

EMPLOYER NAME: ______________________________ OCCUPATION: ____________________
(If child, please give insurance holder's employment)

BUSINESS ADDRESS: ________________________ CITY ____________ STATE ______ ZIP ________

NEAREST RELATIVE NOT LIVING WITH YOU: ____

____
(Address) *(City)* *(State)* *(Phone)*

REFERRAL BY: ☐ Dr. ____________________ ☐ Family ____________________ ☐ Other ____________________

☐ Friend ________________ ☐ Insurance Company ☐ Sign/Location ☐ Phone book ☐ Website

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PRIMARY INSURANCE: ____

POLICY HOLDER'S NAME: ____

INSURED'S DATE OF BIRTH: _____/ ______/_____ SEX: M or F RELATIONSHIP: ☐ Spouse ☐ Parent ☐ Other
(If not self)

SECONDARY INSURANCE: ____

POLICY HOLDER'S NAME: ____

INSURED'S DATE OF BIRTH: _____/ ______/_____ SEX: M or F RELATIONSHIP: ☐ Spouse ☐ Parent ☐ Other
(If not self)

OVER

REASON FOR YOUR VISIT: ____

____

PHARMACY : ____

(Name) *(Street)* *(City)* *(Phone)*

INSURANCE, ASSIGNMENT AND HIPPA AUTHORIZATION

Co-payments are due at the time of service. We will bill all contracted insurance companies, however you are ultimately responsible for all charges whether or not paid by your insurance company. For your convenience we do accept Checks, Cash, Visa or Mastercard.

I hereby authorize Neamand Foot & Ankle Center and/or its staff to disclose my individually identifiable health information to the insurance carrier(s). Neamand Foot & Ankle Center will use and disclose my health information in order to obtain payment to the doctor for services rendered and allow insurance companies to process the claims. This includes disclosing your protected health information to other physicians who treat you or to home health agencies that provide care to you. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Patient, Guardian &/or Insured Signature ____Date: ____________