WELCOME TO ELITE SPORTS PODIATRY

Patient Information Form

Name_____ Street_____

City_____ State_____ Zip_____ Home Phone_____

Social Security # _____ Date of Birth_____ Sex: M F Marital Status S M W
please circle one of the above

Patient's employer_____ Work # _____ Spouses Name _____

How did you hear about our office?_____ E-mail address: _____

Primary Physician _____ Address_____ Phone_____

Date of last visit to Primary Care Physician:_____

Is a referral required by your insurance company? Yes ___ No___ If yes, did you already obtain it? Yes ___ No___

Please fill this section out if the policyholder **is other than yourself** or the **patient is a minor** or if there is no insurance and **someone else is responsible for payment.**

Name_____ Address_____

Relationship_____ Home Phone _____ Work Phone_____

Social Security #_____ Date of Birth_____

Insurance Company: Policy # Group # Co-Pay Referral required

1._____

2._____

Person to notify in case of emergency:

Name_____ Relationship_____ Phone _____

AUTHORIZATIONS

Benefits to Physician

INITIALS **I HEREBY AUTHORIZE PAYMENTS TO THE PHYSICIAN FOR SURGICAL/MEDICAL BENEFITS**

_____ I understand and agree that I am responsible for any balance of my bill not paid by my insurance company for any professional services rendered. I also understand that it is my responsibility to notify the office of any changes in my health status, primary care physican and insurance policy/status.

Release of Information

I HEREBY AUTHORIZE RELEASE OF INFORMATION FOR INSURANCE CLAIM PURPOSES.

YES NO The information authorized for release may include information that may be considered a communicable or venereal disease including hepatitis, syphilis, gonorrhea, HIV and AIDS.

I UNDERSIGNED ALL OF THE ABOVE AND HEREBY STATE THAT THE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

X_____ **DATE**_____

Signature of Patient/Responsible party