

# PATIENT INFORMATION

PLEASE PRINT CLEARLY & PROVIDE PHOTO ID

**Foot First**  
Podiatry Centers P.C.

Patient Name ..... Sex M  F   
LAST FIRST MIDDLE INITIAL

Birthdate ..... Age ..... Social Security No. ....

Marital Status Single  Married  Divorced  Widowed  Spouse Name or Responsible Party .....

Address ..... City ..... State ..... Zip Code .....  
+4 DIGITS AFTER ZIP CODE

Home Phone ..... Cell Phone ..... Business Phone .....

Email Address .....

Employer Name ..... Occupation .....

Business Address ..... City ..... State ..... Zip Code .....  
+4 DIGITS AFTER ZIP CODE

Nearest Relative not living with you ..... Phone .....

Address ..... City ..... State ..... Zip Code .....  
+4 DIGITS AFTER ZIP CODE

Referral by  Dr. ....  Friend .....  Website  Other .....  
 Insurance Company .....  Sign/Location  Yellow Pages  
 Flyer (must be presented at first appointment)

## INSURANCE INFORMATION

**Please note:** if you do not provide the correct insurance information at the time of your visit, we will be unable to bill your insurance company. You will then be responsible for payment in full at the time of the visit. Please provide a copy of your insurance card (s).

Policy Name ..... Policy Holder's Name .....

Insured's Date of Birth ..... Sex M  F  Relationship Spouse  Parent  Other .....

Secondary Policy ..... Policy Holder's Name .....

Insured's Date of Birth ..... Sex M  F  Relationship Spouse  Parent  Other .....

### INSURANCE AUTHORIZATION AND ASSIGNMENT

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. To avoid late payment fees or finance charges, all unpaid balances must be paid within 30 days. For your convenience we do accept Checks, Cash, Visa, Mastercard, and Discover. **Note:** If paying by credit card, you are authorizing Foot First to keep your signature below on file and to charge the credit card you have selected for any co-payments that are due or towards any balances on your account.

I hereby authorize Foot First Podiatry Centers, V.P.C. / Valley Podiatry Services and/or his/her/its staff to disclose my individually identifiable health information to the insurance carrier(s). Foot First Podiatry / Valley Podiatry Services 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. 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 .....