

# PODIATRIC REGISTRATION AND HISTORY

## 1 PATIENT INFORMATION

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_

Best time and Place to reach you \_\_\_\_\_

E-mail address (optional) \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birth date \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Soc. Sec. No.: \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birth date \_\_\_\_\_ SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Relationship \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

## 2 INSURANCE INFORMATION

Insurance Co. \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Birth date: \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Contract# \_\_\_\_\_ Group # \_\_\_\_\_

Appointment Date \_\_\_\_\_

Is the patient covered by **additional** insurance?

Yes  No If yes, please fill in the following:

Subscriber Name \_\_\_\_\_

Birth date \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Contract# \_\_\_\_\_ Group # \_\_\_\_\_

Who is your Primary Care Physician? (first & last name)

\_\_\_\_\_

Phone \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. David Velarde all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Relationship Date

### MEDICARE AUTHORIZATION

I request payment of authorized Medicare benefits be made either to me or on my behalf to Dr Velarde for services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature request that payment be made and authorize 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 physician 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, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
Beneficiary Signature Date