PATIENT INFORMATION

Name _____ Phone: Cell / Home _____

Address _____ City _____ Zip _____

Date of Birth _____ Age _____ Sex: M F U Marital Status: S M W D

Occupation _____

Employer _____

Work Address _____ Work Phone ( ) _____

E-Mail Address: _____

Spouse _____

Spouse's Employer _____ Work Phone ( ) _____

Closest Relative _____ Relationship _____ Phone ( ) _____

MEDICAL INSURANCE

Company Name _____ Policy Holder's Name _____

Member ID # _____ Group # _____

Other Insurance (*if any*) _____

Medicare: *Yes? No?* Medi-Cal: *Yes? No?* *MAY WE COPY YOUR INSURANCE CARDS?*

Whom may we thank for referring you to our office? _____

Briefly describe your foot problem. _____

_____

I hereby give permission to Benjamin Scherer, D.P.M. and his associates or assistants, to administer treatment as may be deemed necessary in the diagnosis and treatment of my foot condition.

I request that payment of authorized medical insurance or Medicare benefits be made on my behalf directly to Benjamin Scherer, D.P.M. for services furnished to me. I authorize any holder of medical information about me to release to Medicare or any other insurance company or its agents, any information needed to determine these medical benefits. I acknowledge the *Notice of Privacy Practices and HIPAA Compliance* from this office, which describes the use, restrictions and disclosure of my protected healthcare information. I am financially responsible for all non-covered medical services.

_____ _____

Date Signature

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