

PATIENT INFORMATION

NAME _____ PHONE _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ SOCIAL SECURITY NUMBER _____

DATE OF BIRTH _____ SEX _____ WEIGHT _____ HEIGHT _____

SHOE SIZE _____ MARITAL STATUS _____ OCCUPATION _____

EMPLOYER _____ PHONE _____

SPOUSE/GUARDIAN/PARENT (CIRCLE ONE) _____

EMPLOYER _____ PHONE _____

REFERRED BY: _____

INSURANCE INFORMATION

INSURANCE _____

INSURANCE ADDRESS _____ STATE _____ ZIP _____

INSURANCE PHONE # _____ DO YOU REQUIRE A REFERRAL ? YES ___ NO ___

SUBSCRIBERS NAME _____ RELATIONSHIP _____

IDENTIFICATION NUMBER _____ GROUP NUMBER _____

PRIMARY CARE PHYSICIAN _____ PHONE# _____

PHYSICIANS
ADDRESS _____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I HEREBY AUTHORIZE PAYMENT OF INS./MEDICARE BENEFITS TO SHELDON FLEISHMAN, D.P.M.

I AUTHORIZE RELEASE OF ANY AND ALL INFORMATION REQUIRED BY THE INSURANCE COMPANY/ MEDICARE FOR PAYMENT OF BENEFITS

_____/_____
SIGNATURE DATE

FINANCIAL RESPONSIBILITY

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL SERVICES PERFORMED BY DR FLEISHMAN and/or BLUE SPRINGS PODIATRY.

_____/_____
SIGNATURE DATE