DALLAS PODIATRY WORKS

PATIENT INFORMATION

Name:_____Date:_____

Home Phone:_____Work:_____Ext._____Cell:_____

Address:_____

Email Address:_____

Date Of Birth:_____Social Security Number:_____Sex: ( )M( )F

Race:_____Ethnicity:_____Primary Language:_____

Pharmacy Address phone#:_____

Whom may we thank for referring you?_____

INSURANCE INFORMATION

Primary Insurance CompanyName:_____

ID/Member #_____Group Number:_____

Policy Holder name:_____ DOB:_____ Relationship to patient:_____

Secondary Insurance Company Name:_____

ID/Member #_____Group Number:_____

Policy Holder name:_____ DOB:_____ Relationship to patient:_____

EMERGENCY CONTACT INFORMATION

Name:_____Address:_____

Home phone:_____Cell :_____Work:_____Ext_____

EXPLANATION OF PAYMENT POLICY AND PRIVACY POLICY

I hereby authorize Dallas Podiatry Works, PA to release information pertinent to the filing of insurance claims for the patient named above. I authorize my insurance carriers to pay benefits directly to Dallas Podiatry Works, PA on any unpaid services filed on my behalf. I understand that I am responsible for paying Dallas Podiatry Works PA for charges for the above patient regardless of my insurance coverage. I also understand that Dallas Podiatry Works PA is not ultimately responsible for collecting my insurance or negotiating settlements of claims. I acknowledge that I was provided a copy of the DALLAS PODIATRY WORKS NOTICE OF PRIVACY PRACTICES and that I have had the opportunity to read and understand the notice.

I hereby give Dallas Podiatry Works, PA, permission to diagnose and administer treatment for my foot or ankle condition and authorize any release of information obtained during my treatment.

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Patient/ legal guardian signature Date