Dallas PODIATRY Works
Part of StrideCare

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 Company Name:_____

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:_____

Cell:_____Home Phone:_____

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**