Coastal Podiatry Associates

WELCOME! YOUR FOOT HEALTH IS OUR UTMOST CONCERN

Patient's Legal Name: Last First M | Sex: M ☐ F ☐ | Age ______ Birth Date: ___/___/___ | Patient's Social Security #:

Address | City: | State | Zip: | Marital Status; S ☐ M ☐ W ☐ D ☐

Home Phone: | Business Phone: | Cell Phone: | E-mail:

Name of Employer: | Address: | State: | Zip: | Business Phone: | Occupation:

Patient's Race: White ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hawaiian Native/Pacific Islander ☐

Patient's Ethnicity: Hispanic or Latino ☐ Non Hispanic or Latino ☐

Patient's Referred Language: English ☐ Spanish ☐ French ☐ Russian ☐ Italian ☐ Dutch ☐ Other ☐

Do you smoke? Yes ☐ No ☐; If yes, do you smoke every day? Yes ☐ No ☐. Are you a former smoker? Yes ☐ No ☐

Spouse's Name: | Spouse's Birth Date: Birth Date: ___/___/___ | Spouse's Social Security #:

Spouse's Employer: | Address: | State: | Zip: | Business Phone: | Occupation:

Responsible Party: Self ☐ Spouse ☐ Parent ☐ | Address: | City: | State: | Zip: | Responsible Party Phone:

Which of the following aided you in coming to our office for treatment?

Frontier Phone book ☐ HTC Phone book ☐ Doctor ☐ Friend ☐ Internet/Website ☐ Other ☐ (please specify)

Primary Insurance Company: | Patient's Relationship to Subscriber: Self ☐ Spouse ☐ Parent ☐ | Is Insurance Through Your Employer? Yes ☐ No ☐

Subscriber Name: | Subscriber Birth Date: ___/___/___ | Subscriber Social Security# | Policy #: | Group #:

Secondary Insurance Company: | Patient's Relationship to Subscriber: Self ☐ Spouse ☐ Parent ☐ | Is Insurance Through Your Employer? Yes ☐ No ☐

Subscriber Name: | Subscriber Birth Date: ___/___/___ | Subscriber Social Security# | Policy #: | Group #:

I authorize Coastal Podiatry Associates to call me at work regarding medical and appointment information when necessary.
Yes ☐ No ☐ Not Applicable ☐

I authorize Coastal Podiatry Associates to leave specific medical and appointment information on my answering machine/voice mail if they are unable to personally contact me. Yes ☐ No ☐ I do not have an answering machine or voice mail. ☐

I authorize Coastal Podiatry Associates to release specific medical and appointment information to the following persons: (if not authorizing release, write NONE) ____________________

Patient/Guardian Signature ____________________ Date ____________

Medicare Lifetime Signature On File:

I request payment of authorized Medicare benefits to Coastal Podiatry Associates for any services furnished to me by Coastal Podiatry Associates. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

Patient Signature ____________________ Date ____________

Private Insurance Authorization For Assignment Of Benefits Information Release:

We only bill those insurance companies in which we are participating providers. However as a courtesy to our patients, we will file your insurance for surgeries and tests.

I, the undersigned, authorize payment of medical benefits to Coastal Podiatry Associates for any services furnished to me by Coastal Podiatry Associates. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company, or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claim of benefits.

Patient, Parent or Guardian Signature (if child under 18 years old) ____________________ Date ____________