NORTHSIDE PODIATRY PC

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INSURANCE - PLEASE PRESENT YOUR INSURANCE FORMS, CARDS AND IDENTIFICATION TO THE RECEPTIONIST

PATIENT INFORMATION

Date	Patient: Last Name	First	Middle

Home Address	City	State	Zip

Home Phone #	Social Security Number	Sex	Birthdate	Age
( ) -	- -	☐ M ☐ F	/ /	

Marital Status:	Employed	If a student
☐ Single ☐ Married ☐ Divorced ☐ Widowed	☐ Yes ☐ No	☐ full time ☐ part time

Responsible party: (for minor) Name Address
(Parent or guardian)

Patient's Employer	Occupation

Business Address City State Zip code	Work Phone #	Cell Phone #
	( ) -	( ) -

Primary Care Physician : First & Last Name	address	Phone Number
		( ) -

When was your last visit with the Primary Care Physician _____(Mo /date/yr)

Referred by: ☐ Physician:_____ ☐ Patient _____ ☐ Ins. Co. (☐ Web ☐ Book)

☐ Yellow Pages ☐ Our Web Site ☐ Other _____

Emergency Contact: Name,	Phone Number	Relationship

Primary Insurance Carrier Name: Primary Policy Holder Insured Date of Birth
/ /

Secondary Ins. Co. Insured Date of Birth Race Ethnicity
/ /

email address: _____

May we notify you via email of recent medical \ practice updates and appointment notification?
☐ Yes ☐ No

Pharmacy Name & Location

Pharmacy Phone #
( ) -

My insurance contract is between the insurance company and me. The doctor does not set the amount paid and I am financially responsible to Northside podiatry PC for any charges not covered by the insurance policy. I authorize the release of any medical information to process my insurance claim. I assign payment of medical or surgical benefits directly to Northside Podiatry PC for services rendered.

X_____ Date:_____

Today, I will pay my bill by: ☐ Cash ☐ Check ☐ MC ☐ Visa ☐ American Express

Please Note: Payment is expected in full at the time of medical care. Your copay and / or deductible are due today. Thank You.