All Island Foot Care

IN ORDER TO FACILITATE YOUR TREATMENT
PLEASE ANSWER THE FOLLOWING QUESTIONS

DATE _____

NAME MR. / MRS. / MISS _____

HOME ADDRESS _____ CITY _____

ZIP CODE _____ DATE OF BIRTH _____ SS# _____

PHONE _____ CELL _____ Email _____

PRINCIPAL COMPLAINT _____

Have you had previous care by a foot specialist? _____

FAMILY PHYSICIAN _____ PHONE _____

OCCUPATION _____ BUS. PHONE _____

NAME OF PARENT OR SPOUSE _____

NEAREST RELATIVE NOT LIVING WITH YOU _____ PHONE _____

NEAREST FRIEND NOT LIVING WITH YOU _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU TO US?

_____

I WILL BE PAYING TODAY BY CASH _____ CHECK _____

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

HEALTH INSURANCE _____ We are always happy to assist patients to receive money back from their insurance companies if their treatment is covered by their policies.

_____
Name of Insured Date of Birth Social Security #

_____
Place of Employment (Insured)

_____ Date _____
Signature of Patient

_____ Date _____
Signature of Parent (if minor)

Podiatric Medicine and Surgery