Personal Information

Family Podiatry Center

Patient Name: ______________________ Marital Status: Married ☐ Single ☐ **Spouses Name**: __________ Widowed ☐

Address: ______________________ City: __________ Zip: __________ Home Phone: __________

Email: ______________________ Cell Phone: __________

Social Security Number: ______________________ Date of Birth: __________ Sex: M ☐ F ☐

Guardian's Name: ______________________ Social Security #: __________

Student Status: Not A Student ☐ Full-Time ☐ Part-Time ☐ **How did you find out about us**: __________

In an emergency, we should contact: Name: ______________________ Phone: __________

Patient Employment Status: F/T ☐ P/T ☐ Retired ☐ Not Employed ☐

Employed by: ______________________ Address: __________ City: __________ Zip: __________

Phone No.: ______________________ Occupation: __________

Name of Medical Insurance Company: ______________________ Address: __________ City: __________ Zip: ______

Phone: ______________________ Group Number: __________ I.D. Number __________

Policy Holder Information: Name: ______________________ Date of Birth: __________ Social Security #: __________

Employed by: ______________________ Address: __________ City: __________ Zip: __________

Employer Phone: ______________________

Name of Other Health Insurance: ______________________ Address: __________ City: __________ Zip: __________

Phone No.: ______________________ Group Number: __________ I.D #: __________

Policy Holder Information: Name: ______________________ Date of Birth: __________ Social Security #: __________

Employed by: ______________________ Address: __________ City: __________ Zip: __________

Employer Phone: ______________________

RELEASE & ASSIGNMENT

To: (Insurance Company): ______________________ RE: (Patient Name) __________

Group Number: ______________________ I.D. Number: __________

I acknowledge that the insurance information that I am providing is current and complete and I hereby authorize Dr's. Reid/Kosova, and his/her associates, to release to your company or its representatives, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical or Surgical care. Furthermore, I authorize them to file any necessary complaints to the Illinois Insurance Commissioner on my behalf.

I also authorize and request your company to pay directly to the above named doctor and his/her associates who agree to provide health-care related services, the amount due me in my pending claim for Basic Medical, Major Medical and/or surgical treatment or services, by reason of such treatment or services rendered to me. I assign right of reimbursement for services, cause of actions and remedies in pursuing such reimbursement.

I accept complete responsibility for and guarantee full and timely payment to this office. This includes charges not covered by my insurance and any costs associated with collections, associated court costs, and attorney's fees. Unpaid accounts will bear interest at 12% per annum.

Patient Signature: ______________________ **Date:** __________

Signature of Witness: ______________________ **Date:** __________

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose).

Patient Signature: ______________________ Date: __________

Parent or Authorized Representative (if applicable) ______________________