New Patient Information Record

Jonathan Bennett, DPM, Michael Poliskie, DPM, Corey LeJeune, DPM, Stephanie Nanson, DPM

Patient's Name:_____Birth Date:_____ Age:_____
Nombre Middle Apellido (fecha de nacimiento) (edad)

Address_____ City_____Zip code_____
(direction) (cuidad) (codigo postal)

Home Phone_____Cell Phone_____Email address_____
(casa telefono)

Drivers Lic #_____ SSN_____Marital Status_____

Patient Employer_____Occupation_____FT / PT_____
(empleador)

Employer address_____ Employer Phone #_____

Is patient a student? ___full time ___part time Name of school_____

Spouse/Co-Habitor_____Birth Date_____
(esposo/a) (first name / nombre) (Middle) (last name / apellido)

Spouse Employer_____Occupation_____

Employer Address_____Phone_____

Spouse's SSN_____

Relationship to person responsible for payment:_____

Responsible Person_____Birth Date_____SSN_____

Responsible person address_____Phone_____

Responsible person employer_____ FT/PT_____ Occupation_____

Referred by_____ Phone/Address_____
(referido por)

Friend to contact in case of emergency_____ Phone_____

Insurance Information *(Receptionist will copy your insurance card(s))*

Do you have group medical insurance? ___Yes ___No

Insurance Co._____ Medicare: ___Yes ___No Medicare No._____

Medical/CalOptima: ___Yes ___No Medical/CalOptima No._____

Release of Information / Assignment of Benefits

I hereby authorize Dr. Bennett, Dr. Poliskie, Dr. LeJeune, Dr. Nanson to disclose when requested by the above named insurance carrier or its representatives any and all information with respect to any illness or injury(s), medical history or treatment and copies of all medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

Date:_____ Signature:_____

I hereby authorize payment directly to Dr. Bennett, Dr. Poliskie, Dr. LeJeune, Dr. Nanson of the surgical and/or medical benefits, if any. Otherwise payable to me for professional services rendered to me. I understand that I am financially responsible for the charges not covered by this authorization. I further agree in the event of non-payment, to bear the cost of reasonable legal fees should this be required.

Date:_____ Signature:_____