CARLOS F. SMITH, DPM

PATIENT INFORMATION

PLEASE PRESENT INSURANCE CARDS TO RECEPTIONIST FOR PHOTOCOPING

Name:_____ Email Address_____
First Middle Last

Address: _____ Phone (Home) _____

City _____ State _____ Zip _____ Phone (Work) _____

Date of Birth _____/____/_____ Age _____ Sex M F Social Security Number _____/_____/_____

Marital Status (Circle One) Single Married Divorced Widowed Other

Occupation _____ Employer _____

Spouse's Name _____ Date of Birth _____/_____/_____

Spouse's Occupation _____ Employer _____ Phone (Work) _____

Primary Insurance _____

Subscriber/Cardholder _____ Date of Birth _____/_____/_____

Employer _____ Phone (Home) _____ Phone (Work) _____

ID/SSN _____ Group No _____ Relationship to Patient _____

Insurance Address _____

City _____ State _____ Zip _____ Ins Phone No _____

Secondary Insurance _____

Subscriber/Cardholder _____ Date of Birth _____/_____/_____

Employer _____ Phone (Home) _____ Phone (Work) _____

ID/SSN _____ Group No _____ Relationship to Patient _____

Insurance Address _____

City _____ State _____ Zip _____ Ins Phone No _____

History of Illness (Please circle all that apply) Diabetes Anemia Asthma Stomach Ulcer Rheumatic Fever

Heart Attack Gout Cancer High Blood Pressure Other _____

Family Physician _____ Requested Visit: Yes No

List all medications, the problem, and the length of time presently taking _____

_____

_____

ALLERGIES (Please circle all that apply) Penicillin Codeine Novocain Aspirin Sulpha Drugs

Adhesive Tape Iodine Other _____

My foot problem involves my (please circle one) left foot right foot both feet

It has troubled me for _____days _____ weeks _____months

Shoe size _____ Weight _____ Favorite shoes _____

State in your own words, your medical reasons for coming to the office _____

_____

Have you seen a Foot Specialist before? Yes No Reason _____

_____

Whom may we thank for referring you to our office _____

Women only: Are you pregnant? Yes No

Authorization/Responsibility Agreement

I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to **Carlos F. Smith, DPM**. A copy of this can be considered as an original for insurance purposes.

Signature _____ Date _____

I hereby agree to pay my account as services are provided. If for any reason there is a balance owing on my account, I agree to pay promptly upon receipt of the month statement.

Signature _____ Date _____

I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family.

Although I have requested the doctor to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance company, I further agree to make arrangements for prompt payment of the bill.

Signature _____ Date _____