CARLOS F. SMITH DPM

PATIENT INFORMATION

PLEASE PRESENT INSURANCE CARDS TO RECEPTIONIST FOR PHOTOCOPYING

Name:____

(First) **(Middle)** **(Last)**

Address:______________________________ **Phone (Home)**________________

City:________________ **State:**_____ **Zip:**_________ **Phone (Work)**________________

Date Of Birth:____/____/____ **Age:**___ **Gender: Male**___ **Female**___ **Social Security #**_______/_______/_______

Marital Status (circle one) Single Married Divorced Widowed Other

Occupation:________________________ **Employer:**________________________

Spouse's Name:______________________ **Date Of Birth:**_____/_____/______

Spouse's Occupation:____________________ **Employer:**______________________

Primary Insurance:____

Subscriber/Card Holder:____

Employer:________________________ **Phone (work)**______________________

ID/SSN:______________________ **Group No:**__________ **Relationship To Patient:**__________

Insurance Address:____

City:________________ **State:**_________ **Zip:**________ **Ins Phone No:**________________

Secondary Insurance:____

Subscriber/Card Holder:____

Employer:________________________ **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, 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, Novacaine, Aspirin, Sulpha Drugs,

Adhesive Tape, Iodine Other:____

My foot problem involves my: Left Foot Right Foot Both Feet (please circle one)

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 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:_______________