

## Patient Information

Date: \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Doctor's Phone Number \_\_\_\_\_

Patient's Name \_\_\_\_\_  
(LAST) (FIRST) (MI)

Home Address \_\_\_\_\_ Apt # / Lot \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_ E-Mail \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Social Security Number \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Employed by \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

### Financially Responsible Party (Spouse/Parent) Information

Name \_\_\_\_\_  
(LAST) (FIRST) (MI)

Social Security Number \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Employed by \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

### Emergency Contact

Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

### Insurance Information

Primary Insurance \_\_\_\_\_

Primary Card Holder Name \_\_\_\_\_

Plan:  Aetna  BC/BS  Cigna  Medicare  United HealthCare  Tricare

Secondary Insurance \_\_\_\_\_

Primary Card Holder Name \_\_\_\_\_

Plan:  Aetna  BC/BS  Cigna  Medicare  United HealthCare  Tricare

For Office Use: Account Number: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OR RECEIPT OF MEDICAL INFORMATION**

**AND**

**AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**

I hereby grant Adler Podiatry and Wound Care, LLC the authority to seek, receive, release, or transmit any and all information pertaining to me as may be necessary to process my insurance claim(s) and to bill and receive payment from my insurance company for any and all services rendered to me by Adler Podiatry and Wound Care, LLC or its designees.

I hereby agree to pay Adler Podiatry and Wound Care, LLC, in a timely fashion, for any and all services rendered which may or may not be covered by my insurance. This includes all co-payments and/or insurance payments that I may receive as a result of services rendered by Adler Podiatry and Wound Care, LLC. In the event that a collection service is required to collect any unpaid balance, I agree to pay any additional costs which may be applied by the collection service.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

(Relationship if other than patient) \_\_\_\_\_

FOR OFFICE USE

COPY OF DRIVER'S LICENSE AND INSURANCE CARD