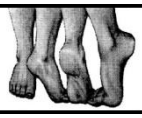

EAST OCEAN PODIATRY

PHONE: (954) 481-3525

PATIENT INFORMATION

820 East Hillsboro Blvd. Deerfield Beach, Florida 33441 **Fax: (954) 481-1620**

(***PLEASE*** complete and ***PRINT*** in all applicable spaces)

First Name: _____ MI: _____ Last Name: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Physician: _____ Phone: _____ Last seen: _____

Employer Name/ Address: _____ or Student: Yes / No

Gender: M / F Social Security: _____ Marital Status: _____

I would like to receive quarterly newsletters ☐ E-mail: _____

or scan to join now!

PRIMARY INSURANCE INFORMATION

Insurance Name: _____ If necessary did you bring your referral: Yes / No / NA

Insurance Phone # for providers: _____ Claims Address: _____

Policy/Member: _____ Group / Account Number: _____

Primary Insured's Full Name: _____ Date of Birth: _____ Social Security: _____

Gender: M / F Primary Insured's home address: _____

Employer's Name: _____ Phone: _____

PRIVACY INFORMATION

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Names of family/friends who can pick up your medical records and/medical supplies: _____

Names of family/friends that have parents' authorization to bring in the minor child when guardian is absent:

I certify that the above and attached information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary to the diagnosis and/or treatment of me or my child's condition. As a representative of myself or as a guardian, I give authorization for the above listed patient to receive medical and/or surgical care and treatment with any of the doctors at East Ocean Podiatry.

Representative's Signature: _____ Date: _____