

Patient Information - Update

Welcome we are delighted to see you again!

Please take a few minutes to help us update our records. Today's Date: _____

NAME: MR. MRS. MS. _____

Has your name changed since you were last in? Y N Has your address changed? Y N

HOME ADDRESS: _____ CITY _____ STATE _____ ZIP _____

HOME PHONE: () _____ MARITAL STATUS: S M D W

SPOUSES NAME: _____ **YOUR OCCUPATION:** _____

YOUR EMPLOYER: _____ **WORK PHONE:** () _____

IF THE PATIENT IS A DEPENDENT, WHO IS RESPONSIBLE FOR PAYMENT: _____

NAME	ADDRESS	PHONE
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RELATIONSHIP - Spouse

Child

Other

PLEASE PRESENT YOUR INSURANCE CARD DURING REGISTRATION

IS THIS A NEW INSURANCE? Y N

PRIMARY INSURANCE: _____ **POLICY #** _____ **GROUP** _____

POLICY HOLDERS NAME: _____ **ADDRESS:** _____

HEIGHT: _____ **WEIGHT:** _____ **SHOE SIZE:** _____

NAME OF YOUR MEDICAL DOCTOR: _____ **PHONE#** () _____

LIST ALL MEDICATIONS/DOSAGES CURRENTLY TAKEN: _____

DO YOU HAVE ANY MEDICATION or other ALLERGIES-LIST: _____

Any SURGERIES since you were last in? : _____

PLEASE LIST ANY NEW MEDICAL PROBLEMS ILLNESS, ACCIDENTS: _____

****OFFICE POLICIES****

*****It is your responsible to provide your insurance CARD and information to the office.**

***** Please report any insurance changes Promptly to avoid uncovered expenses to you.**

*****Co-payments, Deductibles, uncovered services or supplies require payment at the time of your office visit.**

Please be prepared to make any payments at the time of your visit. Please contact your insurance carrier for questions regarding limitations specific to your policy contract. Our office does not have this information. You will be billed \$25.00 for missed office visits without 24 hour notice-emergencies-Illness are exempt, Please call to let us know as soon as possible.

You are financially responsible for payment for any excluded treatments/supplies not covered under your policy, especially if you fail to provide the office with accurate insurance information. There is a \$25.00 billing charge to rebill with your correct insurance information.

Your medical and personal information is **private** and used only by Dr. Scheinin and his associates/office staff as needed for your treatment and to process your insurance claims. We do not keep any copies of your I.D. These are required by credit Laws to verify your identity.

Assignment and release: I hereby assign my insurance benefits to be paid directly to Gary Scheinin, D.P.M. I also authorize Dr. Scheinin to release any information required in processing my insurance claim. I consent to evaluation, management and treatments for my medical problem by the doctor, his associates and his staff. I authorize Dr. Gary Scheinin to obtain medical records as needed for my treatment from laboratories, radiology facilities and other physicians/medical providers.

Patient Signature

Date

Relationship to patient if Minor