

**GARY S. SCHEININ, D.P.M., APC**  
**SPECIALIST & SURGEON OF THE FOOT & ANKLE**  
 Board Certified In Foot & Ankle Surgery  
Please fill out this form completely

NAME: MR. MRS. MS. Dr. \_\_\_\_\_ BIRTH DATE \_\_\_/\_\_\_/\_\_\_ AGE \_\_\_

HOME ADDRESS Not a PO Box: \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_ ZIP \_\_\_\_\_

HOME PHONE: ( ) \_\_\_\_\_ SS #: \_\_\_/\_\_\_/\_\_\_ MARITAL STATUS: S M D W

CELL PHONE #: ( ) \_\_\_\_\_ - \_\_\_\_\_ DRIVERS LIC. #-STATE: \_\_\_\_\_

SPOUSES NAME: \_\_\_\_\_ YOUR OCCUPATION: \_\_\_\_\_

YOUR EMPLOYER: \_\_\_\_\_ WORK PHONE: ( ) \_\_\_\_\_

**IF THE PATIENT IS A DEPENDENT OR IF YOU ARE NOT THE INSURANCE SUBSCRIBER WHO IS RESPONSIBLE FOR PAYMENT?**

NAME	ADDRESS	PHONE	DATE OF BIRTH
EMPLOYER	WORK PHONE NUMBER		RELATIONSHIP TO PATIENT

**\*PLEASE PRESENT YOUR INSURANCE CARD DURING REGISTRATION AND AT EACH VISIT\***

PRIMARY INSURANCE CO: \_\_\_\_\_ POLICY # \_\_\_\_\_ GROUP \_\_\_\_\_

POLICY HOLDERS NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

**PLEASE REPORT YOUR:** HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ SHOE SIZE: \_\_\_\_\_

NAME OF YOUR MEDICAL DOCTOR: \_\_\_\_\_ PHONE# ( ) \_\_\_\_\_

\* Who May We Thank For Referring You To My Office: \_\_\_\_\_ ?

**\*\*OFFICE POLICIES\*\***

- \*\*\*You are 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.**

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.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_ Relationship to Patient if Patient is a Minor \_\_\_\_\_