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:_____CITY_____STATE_____ZIP_____

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

E-MAIL: _____ **D.L.#-STATE:** _____**SS#** _____/____/_____

SPOUSES NAME:_____ **PATIENT** OCCUPATION: _____

PATIENT EMPLOYER: _____ WORK PHONE: ( ) _____

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

PRIMARY INSURANCE CO.: _____

POLICY HOLDER: II SELF II SPOUSE II DEPENDENT

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

NAME **RELATIONSHIP TO PATIENT** **DATE OF BIRTH**

EMPLOYER **WORK PHONE NUMBER**

PLEASE REPORT YOUR: **SHOE SIZE**:_____ **HEIGHT**: _____ **WEIGHT**:_____

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 **$50.00** 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