

## Patient Information Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SS#: \_\_\_\_\_ Sex: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph#: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Allergies: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Referred By: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_

### Responsible Party

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph#: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Ph#: \_\_\_\_\_

### Insurance

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Insured: \_\_\_\_\_ Insured: \_\_\_\_\_

Insured DOB: \_\_\_\_\_ Insured DOB: \_\_\_\_\_

Insured ID#: \_\_\_\_\_ Insured ID#: \_\_\_\_\_

Group #: \_\_\_\_\_ Group #: \_\_\_\_\_

### Authorization

I hereby authorize release of information necessary for my insurance company to process my claim. The above information is correct to the best of my knowledge.

I hereby authorize payment directly to Matthew Richins DPM insurance benefits otherwise payable to me. I understand that I am financially responsible for charges not paid in a timely manner by my insurance.

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