

CORAL RIDGE PODIATRY
2737 E. Oakland Park Blvd.
Ft. Lauderdale, Fl 33306
(954) 561-3338

Welcome to our office:

Date: _____

Account #

Please answer all questions and sign where indicated. Please include both sides of this form.

LAST NAME: _____ M.I. _____

FIRST NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: () _____

CELL PHONE: () _____

BUSINESS PHONE: () _____

EMAIL: _____

BIRTH DATE: _____ SOC SEC# _____

MARITAL STATUS: S M D W

SPOUSE/PARTNER NAME: _____

PLEASE TELL US WHO REFERRED YOU TO OUR OFFICE:

1. A patient? _____
2. A Physician? _____
3. A hospital referral service? _____
4. A newspaper/magazine? _____
5. Television? _____
6. Your health plan provider list? _____
7. The Yellow Pages? _____
8. The Internet? _____

Who is your Primary Care Physician? _____

Phone: _____ Fax: _____

INSURANCE INFORMATION

Who is your Insurance carrier? _____

Are you the policy holder? Yes No

If you are NOT the policy holder, what is your relationship to the policy holder?

Spouse Dependent child Dependent child over 18 and a full time student

Policy holders name (IF NOT YOU) _____

Policy holders SS# _____ Date of Birth: _____

READ AND SIGN BELOW

I hereby give permission for Coral Ridge Podiatry to share my medical records with my insurance carrier upon their written request for the benefit of supporting my medical treatment at this office. I also do hereby give permission for Coral Ridge Podiatry to bill my insurance carrier for the purposes of obtaining payment for services rendered here at this office.

Print your name _____ Date _____

Sign your name _____ Date _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES.

I acknowledge that a copy of the Notice of Privacy Practices is available to me upon request. I have read, or have had the opportunity to read them if I so choose and understood the Notice.

Print your name _____

Sign your name _____

Please provide a list of your current medications here, or you may provide them under separate cover.

_____	_____
_____	_____
_____	_____
_____	_____

It is the patient's responsibility for knowing the benefits provided by his/her health care plan. Our office is under no obligation to inquire about your insurance benefits.

I hereby give my permission to allow Dr. Gary Wallach, D.P.M. to examine and treat my feet. To the best of my knowledge the above information is accurate and complete.

PATIENT, PARENT OR GUARDIAN'S SIGNATURE