Alamitos - Seal Beach Podiatry Group

Welcome to our office! Thank you for taking a few minutes to provide us with the following information.

	PATIEN	T INFORM	ATION PLEAS						
PATIENT'S NAME:				SEX:	BIRTHDATE:	S	CIAL SECURITY	NUMBER:	
			FFW/Viscos/AM	☐ MALE	1				
LAST FIRST			INITIAL	☐ FEMALE	MO. DAY	YR.	NUMBER:		
ADDRESS:						PHUNE			
STREET		CITY	STATE	ZIP		()		
MAILING ADDRESS (IF OTHER THAN PERMANENT RESIDENCE)						PHONE	NUMBER:		
STREET		CITY	STATE	ZIP		()		
MARITAL STATUS / NAME OF SPOUSE:				T	ENSE NUMBER:			STATE	
□ SINGLE □ MARRIED □ DIVORCED □ MINOR			- K	☐ PATIENT	☐ FATHER ☐ MOTH	ER			
IF MINOR - WHO ASSUMES FINANCIAL RESPONSIBILITY (NAME, ADDRESS & PHONE):									
NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY:					RELATIONSHIP:	PHONE	NUMBER:		
					1	1			
ADDRESS:			CITY			STAT	re	ZIP	
STREET NAME OF FRIEND OR RELATIVE NOT LIVING WITH YOU:			GIT		RELATIONSHIP:		NUMBER:	211	
WANTE OF FRIEND OF REPAIRE NOT EVANO WITH 190.						()		
ADDRESS:					***************************************				
STREET			CITY			STAT	re	ZIP	
EMPLOYED WAY.	E	MPLOYME	NT INFORMAT		1 5 THE RES	Section 1970		□ SPOUSE	
EMPLOYEE'S NAME:		☐ PATIENT or ☐ FATHER	EMPLOTEE S NAM	Ε.				or MOTHER	
OCCUPATION:		BIRTHDATE:	OCCUPATION:		***************************************			BIRTHDATE:	
South Allow									
NAME OF EMPLOYER:	PHONE NUM	BER:	NAME OF EMPLOY	ER:			PHONE NUM	IBER:	
Proportion Company According to Company Compan	()						()		
ADDRESS, STATE & ZIP:			ADDRESS, STATE	& ZIP:					
		NOUBANG							
PRIMARY INSURANCE COMPANY:		INSURANC	E INFORMATION SECONDARY INSU		seale de la companya de la companya Companya de la companya de la compa				
FINIMALL MODIFIANCE COMPLANT.			1						
ADDRESS TO MAIL CLAIMS:			ADDRESS TO MAIL	ADDRESS TO MAIL CLAIMS:					
CITY:	STATE:	ZIP CODE:	CITY:				STATE:	ZIP CODE:	
								L	
I.D. or POLICY NO.	PHONE NO.		I.D. or POLICY NO	I.D. or POLICY NO. PHONE NO.					
	1 ()		GROUP NO.	1 000000000					
GROUP NO.			GROUP NO.						
POLICYHOLDER / SUBSCRIBER:			POLICYHOLDER / S	POLICYHOLDER / SUBSCRIBER:					
TOLIO PROCESSITY GOOD MACINI									
RELATIONSHIP TO PATIENT:			RELATIONSHIP TO	RELATIONSHIP TO PATIENT:					
ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or	surgical benefits, t	o which I am entitle	d, including Medicare, privi	ate insurance, and	any other plan, to Do	ıglas H. R	ichie, D.P.M.	This assignment will	
remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for any co-payments, deductibles or non-covered services.									
*									
(SIGNATURE OF INSURED) (DATE)									
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE:									
NAME:	ADDRESS:			CITY:			STATE:	ZIP CODE:	
			TO THE RESERVE THE PARTY OF THE		****			<u> </u>	
OTHER SOURCE OF REFERRAL:									
□ YELLOW PAGE DIRECTORY □ INSURANCE COMPANY □ HOSPITAL □ OTHER STATE NAME OF DIRECTORY, INSURANCE COMPANY, HOSPITAL, OR OTHER:									
STATE NAME OF DIRECTORY, INSURANCE COMPANY, HOSPITAL, C	STATE BANKE OF DIRECTORS, INCOMINED, THOU STATE, OF COLUMN								
As patient or legal guardian of a minor patient. I agree to pay for all services rendered in accordance with the terms and conditions set forth in the financial									

As patient or legal guardian of a minor patient, I agree to pay for all services rendered in accordance with the terms and conditions set forth in the financial policy of the office of which I have received a copy. In the event legal action should become necessary to enforce payment of any charges, I agree to be responsible for and pay all reasonable attorney's fees and court costs required.

I hereby give my permission to the doctor of Alamitos Podiatry Group to administer treatment, and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition once those procedures have been fully explained to me in advance.

DATE:	SIGNATURE:	