Alamitos - Seal Beach Podiatry Group

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

PATIENT INFORMATION PLEASE PRINT

PATIENT'S NAME: LAST / FIRST / INITIAL	SEX: ☐ MALE ☐ FEMALE	BIRTHDATE: MO. DAY YR.	SOCIAL SECURITY NUMBER:

ADDRESS: STREET / CITY / STATE / ZIP	PHONE NUMBER: ( )

MAILING ADDRESS (IF OTHER THAN PERMANENT RESIDENCE) STREET / CITY / STATE / ZIP	PHONE NUMBER: ( )

MARITAL STATUS / NAME OF SPOUSE: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ MINOR	DRIVER'S LICENSE NUMBER: ☐ PATIENT ☐ FATHER ☐ MOTHER	STATE

IF MINOR - WHO ASSUMES FINANCIAL RESPONSIBILITY (NAME, ADDRESS & PHONE):

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY:	RELATIONSHIP:	PHONE NUMBER: ( )

ADDRESS: STREET / CITY / STATE / ZIP

NAME OF FRIEND OR RELATIVE NOT LIVING WITH YOU:	RELATIONSHIP:	PHONE NUMBER: ( )

ADDRESS: STREET / CITY / STATE / ZIP

EMPLOYMENT INFORMATION

EMPLOYEE'S NAME: ☐ PATIENT or ☐ FATHER	OCCUPATION:	BIRTHDATE:

NAME OF EMPLOYER:	PHONE NUMBER: ( )

ADDRESS, STATE & ZIP:

EMPLOYEE'S NAME: ☐ SPOUSE or ☐ MOTHER	OCCUPATION:	BIRTHDATE:

NAME OF EMPLOYER:	PHONE NUMBER: ( )

ADDRESS, STATE & ZIP:

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:	SECONDARY INSURANCE COMPANY:

ADDRESS TO MAIL CLAIMS:	ADDRESS TO MAIL CLAIMS:

CITY:	STATE:	ZIP CODE:	CITY:	STATE:	ZIP CODE:

I.D. or POLICY NO.	PHONE NO. ( )	I.D. or POLICY NO.	PHONE NO. ( )

GROUP NO.	GROUP NO.

POLICYHOLDER / SUBSCRIBER:	POLICYHOLDER / SUBSCRIBER:

RELATIONSHIP TO PATIENT:	RELATIONSHIP TO PATIENT:

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare, private insurance, and any other plan, to **Douglas H. Richie, 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:

OTHER SOURCE OF REFERRAL:

☐ YELLOW PAGE DIRECTORY ☐ INSURANCE COMPANY ☐ HOSPITAL ☐ OTHER

STATE NAME OF DIRECTORY, INSURANCE COMPANY, HOSPITAL, OR OTHER:

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:**_____