



SOMERSET FOOT AND ANKLE

DEMOGRAPHICS

Patient Name: _____ Patient D.O.B: _____
Preferred Name: _____ Occupation: _____
Marital Status: (S___) (M___) (D___) (W___) (Other___) Spouse's Name: _____
Ins. Policy Holder (Spouse, Parent, Self): _____ Insured D.O.B: _____
Address: _____ Apt #: _____ City: _____
State: _____ Zip Code: _____
Cell Phone: _____ Home Phone: _____
Preferred Method of Contact: (Cell___) (Home___)
EMERGENCY CONTACT
Name: _____ Phone Number: _____
Relationship to patient: _____
Primary Care Doctor: _____ Last Visit: _____
Preferred Pharmacy: _____ Pharmacy Location: _____

***HMO/PPO Signature on File:** I request that payment of authorized benefits be made to Somerset Foot and Ankle for services furnished to me by that physician. I authorize any holder of medical information about me to release to my insurance company or its agents any information needed to determine these benefits or the benefits payable for related service.

Signature: _____ Date: _____

***Medicare Universal Signature on File:** I request payment of authorized Medicare benefits to be made to Somerset Foot and Ankle for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Center for Medicare and its agents any information needed to determine these benefits payable for related services.

Signature: _____ Date: _____

***Secondary Insurance Signature on File:** I request payment of authorized benefits to be made to Somerset Foot and Ankle for any services furnished to me by that physician. I authorize any holder of Medicare and medical information about me to release to my insurance company and its agents for any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____

*I hereby give permission to Dr. Robert Thiele/Dr. Prashant Bhoola to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis/treatment of my foot/feet condition(s).

Signature: _____ Date: _____