

Patient's First Name _____ Last Name _____

Home Address _____ City _____ State _____ Zip _____

Home Phone(____) _____ Work(____) _____ Cell(____) _____

Please indicate your number preference to confirm appointments

Marital Status: (please circle) S M Sep D W Sex: M or F Date of Birth _____ / _____ / _____

SS# _____ / _____ / _____ **Unless ALL information is provided we are unable to bill your Insurance**

Employer Name/Address _____

Occupation/Prior Occupation _____

****INSURANCE INFORMATION****

In addition to the information below – WE MUST HAVE A COPY OF YOUR INSURANCE CARD!

Policy Name _____ Policy Holder's Name _____

Insured's DOB ___/___/___ Sex: M or F Relationship Spouse Parent Other _____

Secondary Policy _____ Policy Holder's Name _____

Insured's DOB ___/___/___ Sex: M or F Relationship Spouse Parent Other _____

If patient is a Minor Please provide name and address of responsible party:

Name _____ Address _____

REFERRED BY: Dr. _____ Friend _____ Other _____
 Website Insurance company Sign

OFFICE POLICY – READ AND REVIEW CAREFULLY:

Please note – there is a \$65.00 fee for any broken, missed or cancelled appointments unless a 48 hour advance notice is given. Patient initials _____

If you do not provide the correct insurance information at the time of your visit, we will be unable to bill your insurance and you will be responsible for payment in full.

Co-payments are due at the time of service. We will bill all contracted insurance companies, however you are ultimately responsible for all charges whether or not paid by your insurance. For your convenience, we accept Cash, Checks, VISA and Mastercard. To avoid late payment fees or finance charges all unpaid balances are your responsibility within 30 days.

Dr. Robinson may inform your other physicians of your podiatric condition to facilitate continuity of care.

I here by assign and request that my insurance benefits be paid directly to Douglas Robinson DPM, PPC. I also authorize the office to release any information required to process my claim(s). A photo copy of this authorization shall be considered as effective and valid as the original. My signature below indicates that I have read, understand and agree to the office policy.

Signed _____ Date _____