

NAME:(LAST) _____ (FIRST) _____
Address: _____ Social Security No: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Marital Status: S _ M _ W _ D _
Birthdate: _____ Age: _____ Sex: _____
Employer: _____ Job Title: _____
Employer Address: _____ Employer Telephone No: _____
City: _____ State: _____ Zip Code: _____
Your E-mail address: _____
Whom should we contact in case of emergency?

Name: _____ Relationship _____
Address: _____ Telephone: _____
City: _____ State: _____ Zip Code: _____
Social Security Number: _____

INSURANCE INFORMATION:

*******Primary Insurance**

Name of Company: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Insured's name: _____ Insured's Date of Birth: _____
Policy Number: _____ Group Number: _____
Insurance Telephone Number: _____

*******Secondary Insurance:**

Name of Company: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Insured's Name: _____ Insured's Date of Birth: _____
Policy Number: _____ Group Number: _____
Insurance Telephone Number: _____

HOW DID YOU HEAR OF OUR OFFICE:

Patient ___ Physician ___ Newspaper ___ Phonebook ___ TV ___ Radio ___ Other ___
If patient or Physician, whom: _____

Please read and sign the statement below:

"I hereby give my permission to Podiatry Associates of Erie, Inc. to administer treatment and/or to perform such procedures as deemed necessary in the diagnosis and/or treatment of my foot problem. I understand I am responsible for the charges for these procedures:

Signature: _____ Date: _____

Signature of Patient or Guardian