

WELCOME TO OUR OFFICE

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 emergeny?

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