Pacific Beach Podiatry

Patient Name: ____**DOB:** ________________________

Address: ____ **City:** ________________________

State: _________________ **Zip Code:** ___________________ **Gender (Circle one):** Male / Female

Drivers License No.:______________________________ **SSN:** ___________________________________

Emergency Contact Name: _____________________________**Emerg Phone :**____________________

Primary Care Physician: ______________________________ **Date Last Seen:** _____________________

Pharmacy Name:______________________________________ **Location:**__________________________

Guarantor Information

(List person or insured name responsible for bill)

***Relationship of Guarantor to Patient: Self ____ Spouse ____ Parent _____ Other ___________________**

Last Name:** ________________________First Name:** _______________________ **Middle:** ________________

***Address:** ____

City: ____________________________________ **State:** _______________________ **Zip:** _______________

Home Phone #: ___________________________ ***Social Security #:** _____________________________

***Date of Birth:** _____________________ ***Sex: Female ______ Male _______**

Insurance Information

(Please allow receptionist to photocopy your insurance ID cards) If someone other than patient is the insured party, please include date of birth of claims

Primary Insurance Name: _________________________________ ***Insured's Name:** ____________________

Insured's Social Security #: ____________________________ ***Insured's Date of Birth:** __________________

***Policy/ID #:** ______________________________ ***Group #:** ____________________ **Eff Date:** ________________

Claims Address & Phone: ____

Secondary Insurance Name: _______________________________ ***Insured's Name:** ___________________

***Insured's Social Security #:** __________________________ ***Insured's Date of Birth:** __________________

***Policy / ID #:** ___________________________ ***Group #:** ____________________ *** Eff Date:** ________________

Claims Address & Phone: ____

***REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING. *ATTACH COPY OF INSURANCE CARDS.**

Patient Name: ____Date of Birth: ______________

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Cheung DPM Professional Corporation or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Cheung DPM Professional Corporation is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Cheung DPM Professional Corporation or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the Cheung DPM Professional Corporation Patient Information Privacy Policy. I hereby authorize Cheung DPM Professional Corporation or the physician individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:
I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Cheung DPM Professional Corporation representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Cheung DPM Professional Corporation to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by my physician or his or her designee.

PATIENT SIGNATURE: ______________________________________ DATE: ___________________

GUARANTOR SIGNATURE: __________________________________ DATE: ___________________