SOUTHERN VERMONT PODIATRY

Patient Name: ____ DOB: _____________ Age: ________

Mailing Address: ________________________________ Town: __________________ State: ____ Zip: _______

Home Phone: _____________________________________ Work Phone: _______________________________

Email: ____

SS#: ____ Marital Status: ______________ Sex: M F

Employer: _______________________________________ Occupation: _______________________________

Primary Care Physician: ____

How do you here about us: □ PCP □ Phone book □ Internet/Website □ Friend □ Other: ___________________

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If Patient is a Minor:

Mother's Name: ____________________________________
☐ Check if address and home phone are the same.
Address (if different than above)
____
____
Home Phone: ______________________________________
Work Phone: ______________________________________

Father's Name: _________________________________
☐ Check if address and home phone are the same.
Address (if different than above)
____
____
Home Phone: ______________________________________
Work Phone: ______________________________________

**************************** **BILLING INFORMATION** ****************************

Insurance information: (please provide insurance cards for copying)

Name, DOB, and SSN of person who carries insurance: ____

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Primary Insurance: ____

Certificate #: ____ Group #: _________________________________

Secondary Insurance: ____

Certificate #: ____ Group#: __________________________________

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If we are unable to reach you, please name someone who could relay a message to you:

Name: ____ Relationship: _______________________________

Home Phone: ______________________________________ Work Phone: _______________________________

May we leave a message on your answering machine or with the person listed about for purposes such as appointment reminders or to call the office? ☐ Yes ☐ No

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Insurance Authorization and Assignment

I give consent for Southern Vermont Podiatry to treat me or the patient for whom I am responsible. I hereby authorize the release of medical information required by my health insurance program for the settlement of claims. I also authorize payment of medical benefits to the undersigned physician, supplier, or service provider. ***I understand that I am responsible for any amount not covered by my insurance.***

Date: _______________________ **Signature:** ____