Welcome to Clinica de los Pies

Patient Information

Patient Name:_____ Sex: M☐ F☐

Address:_____

City:_____ State:_____ Zip Code:_____

Age:_____ Date of Birth:_____ Social Security#:_____

Employer:_____ Employer Telephone#:_____

Employer Address:_____

Spouse Name:_____

Telephone Numbers

Home Phone Number:_____

What is the best time to contact you?:_____

In case of emergency, who would you like us to contact?

Name:_____ Phone Number:_____

Relationship to contact:_____

Insurance Information

Subscriber Name:_____ SS#:_____

Subscriber Date of Birth:_____ Relationship to patient:_____

Insurance Name:_____ Group#:_____

Consent for treatment, assignement of benefits and authorization to release records

I hereby consent to and authorize the administration of all necessary diagnostic and therapeutic treatment for me or my child that may be necessary in the judgement of the attending physician and/or medical personnel. I hereby authorize the above named provider of sevice to furnish information to insurance carriers concerning this illness and I authorize and instruct these same insurance carriers to make payment directly to the above mentioned provider of service for the medical expenses benefit otherwise made payable to me. A photostat copy of the assignment and authorization shall be considered as effective as the original. This lien is irrevocable. I understand that I am financially responsible to the above named provider of service for charges not covered and paid by an insurance carrier.

Patient's Signature (parent/guardian over 18):_____

Date:_____