

INDIAN VALLEY PODIATRY ASSOCIATES, P.C.

PATIENT NAME _____ SOCIAL SEC# _____
(Last) (First) (M.I.) DATE OF BIRTH _____
PATIENT'S AGE _____
ADDRESS _____ SEX M _____ F _____
CITY _____ STATE _____ ZIP _____ Single _____ Married _____
TELEPHONE (_____) _____ - _____ Divorced _____ Widowed _____
E-MAIL ADDRESS _____ Separated _____

PERSON FINANCIALLY RESPONSIBLE FOR PATIENT: Please provide your insurance card (s):

INSURED'S NAME: _____
INSURED'S SOCIAL SECURITY #: _____ INSURED'S DATE OF BIRTH _____
RELATIONSHIP TO PATIENT _____
ADDRESS (IF DIFFERENT FROM PATIENT'S) _____
HOME PHONE# _____ WORK PHONE# _____
EMPLOYER _____ ADDRESS _____
PRIMARY INSURANCE - NAME _____
ID# _____ GROUP# _____

REFERRED BY: _____

MEDICAL INFORMATION:

Please describe your foot problem: _____

Please list any prior surgeries: _____

Are you allergic to any medications? _____ If yes, please explain: _____

Do you have a history of or are you under care for any medical conditions? Please check those that apply:

DIABETES _____ KIDNEY AILMENT _____ FAINTING _____
HEART TROUBLE _____ RHEUMATIC FEVER _____ PHLEBITIS _____
SHORTNESS OF BREATH _____ HIGH BLOOD PRESSURE _____ OTHER: _____
ASTHMA _____ POOR CIRCULATION _____
SEIZURE DISORDER _____ BLEEDING TENDENCY _____

Please list any medications you are currently taking (include vitamins, supplements, aspirin & birth control pills). _____

Name of Family Physician: _____

PATIENT'S INSURANCE AUTHORIZATION

I hereby authorize the processing of the medical insurance either by electronic or manual method by the listed provider below. My signature authorizes payment of all major-medical and/or surgical benefits to which I am entitled from the listed insurer below to pay the listed provider assignee. I further authorize the assignee to release all medical and/or insurance claim information necessary to secure the payment (s). I recognize my financial obligation of any co-insurance or deductible, and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as an original.

Patient's Name (please print)

Patient's Signature

Today's Date

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