Center For Foot And Ankle Care
Nathan Schwartz, D.P.M, FACFAS

PLEASE FILL OUT FORM COMPLETELY

Mr. Mrs. Ms. Miss Name____

Street Address____

City:_________________ State______ Zip Code_______________________________

Social Security_________________ Date of Birth________________ Age________

Home Number________________ Work Number_______________ Cell_______________

Employer_______________ Employer's Address________________________________

Sex_____ Race____ Marital Status____ Spouse's Name_______________________

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Primary Insurance Company____

Policy Holder's Name__________________________Relationship________________

Social Security Number____________________Date of Birth___________________

Policy Holder's Employer _____________________Work Number_________________

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Secondary Insurance Company______________________________________

Policy Holder's Name____

Social Security Number____________________Date of Birth___________________

Policy Holder's Employer________________________Work Number_______________

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Primary Care Doctor_________________________Telephone______________________

If you have Medicare when did you last see your PCP?______________________

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Emergency Contact_______________________Number_______________________

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How did you hear about our office?____

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I understand that I am ultimately responsible for the balance on my account for services rendered. I authorize payment of any medical benefits directly to Center for Foot and Ankle Care for services rendered. I authorize the release of medical information necessary to process any insurance claim.

Patient's Signature or Authorized Person's Signature

____Date______________