The Foot and Ankle Care Center

125 North Robertson Blvd
Beverly Hills, CA 90211

PATIENT INFORMATION

NAME:_______________________________________**DATE OF BIRTH**_____/_____/_____

RESPONSIBLE PARTY:_____________________________**SS#**_______________________

HOME ADDRESS:____**MARITAL STATUS**___

CITY_______________________**STATE**__________**ZIP CODE**________ **SEX M F**

HOME PHONE:_(_____)_________________**CELL PHONE**_(_____)________________

EMAIL ADDRESS:____

OCCUPATION:________________________________**EMPLOYER:**__________________

WORK PHONE:_(_____)____

WORK ADDRESS____

REFERRED BY:________________________**PRIMARY PHYSICIAN:**_________________

PREVIOUS PODIATRIST:____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION OR OTHER INFORMATION NEEDED FOR THE PROCESSING OF MEDICAL CLAIMS AND REQUEST THAT PAYMENT BE MADE DIRECTLY TO THE TREATING DOCTOR. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. IT IS UNDERSTOOD THAT THE PATIENT IS RESPOSIBLE FOR THE MEDICAL SERVICES THEY RECEIVE.

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOOSE) AND UNDERSTOOD THE NOTICE.

I AUTHORIZE HEALTHCARE PROVIDERS AT THE FOOT AND ANKLE CARE CENTER TO TREAT MYSELF OR MY CHILD NAMED ABOVE.

SIGNATURE____**DATE**_____________

(Parent signature if patient is a minor.)