Associated Foot Surgeons

Steven J. Watson, D.P.M.
William H. Dabdoub, D.P.M.

PATIENT INFORMATION

Date _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

Email _____

Sex ❒ M ❒ F Age_____ Birthdate _____

Social Security # _____

❒ Married ❒ Widowed ❒ Single ❒ Minor

❒ Separated ❒ Divorced ❒ Partnered for _____ years

Occupation _____

Patient Employer / School _____

Employer / School Address _____

_____

Employer / School Phone (_____) _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home (_____) _____

Cell (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

Cell Phone (_____) _____

CASH PAY

Responsible Party _____

DOB _____ SSN# _____

INSURANCE

Please provide us with your insurance card.

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient: ❒ Self ❒ Child ❒ Spouse

❒ Other: _____

Insurance Co. _____

I.D. # _____

Group # _____

Is patient covered by a secondary insurance? ❒ Yes ❒ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient: ❒ Self ❒ Child ❒ Spouse

❒ Other: _____

Insurance Co. _____

I.D. # _____

Group # _____

Authorization to Release Information and Assignment of Benefit.

1. I authorize the release of any and all medical information necessary to process this claim.
2. I hereby authorize Associated Foot Surgeons, Steven J. Watson, D.P.M., and/or William H. Dabdoub, D.P.M., to apply for benefits on my behalf for covered services rendered by them, or by their order. I request that payment from my insurance company be made directly to Associated Foot Surgeons.
3. I certify that the information I have reported with regard to my insurance coverage is correct.
4. I understand that I am personally responsible for payment of services rendered.
5. I permit a copy of this authorization to be used in place of the original.
6. I acknowledge that I have been provided with a copy of the Notice of Privacy Practices to read.

_____
Signature (Parent or Guardian if minor)

Date: _____