Capital District Podiatry, PLLC

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Name: ______________________________ **D.O.B:** ____________

Address: ______________________________

City: ____________________ **State:** ________ **Zip-code:** ____________

Home Ph. #: ____________ **Work Ph. #:** ____________ **Cell #:** ____________

Social Security #: ______________________ **Age:** ______ **Sex: M / F**

Employer & Address: ______________________________

Emergency Contact Name: ____________________ **Phone #:** ____________

Primary Insurance: ____________ **Secondary Insurance:** ____________

Referred to us by: ______________________________

Drug Allergies: ______________________________

Reason for visit: ______________________________

Current Medications: ______________________________

Workers Comp or Legal Case: Yes / No (If Yes) Date of Accident: ____________

Address: ______________________________

Phone #: ______________________________

Assignment and Release

I hereby authorize my insurance benefits be paid directly to the physician and acknowledge that I am financially responsible for any unpaid balances. I also authorize the physician to release any information required.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.

SIGNATURE: ______________________ **DATE:** ____________

I ALSO ACKNOWLEDGE RECEIVING THE HIPPA NOTICE OF PRIVACY PRACTICES.

SIGNATURE: ______________________ **DATE:** ____________