ADVANCED PODIATRY GROUP

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PATIENT INFORMATION

NAME: _____ (LAST) _____ (FIRST) _____ (MI)

DATE OF BIRTH: _____ _____ (AGE)

GENDER: □ M □ F □ UNKNOWN

ADDRESS: _____ _____ (CITY . STATE . ZIP)

TELEPHONE #: _____ (HOME) _____ (WORK) _____ (CELL)

EMAIL: _____

SOCIAL SECURITY #: _____

EMPLOYER: _____

MARITAL STATUS: □ Single □ Married □ Widowed □ Divorced □ Separated □ Partnership

EMERGENCY CONTACT: _____

TELEPHONE #: _____

FAMILY PHYSICIAN: _____

TELEPHONE #: _____

WHOM MAY WE THANK FOR THIS REFERRAL: _____

I hereby authorize my insurance company to pay directly to Ramin Nadjafi DPM any and all medical and/or surgical fees otherwise payable to me for their professional services.

I acknowledge that I am personally responsible and liable to Ramin Nadjafi DPM ,for any and all surgical and/or medical fees billed by them. Should Ramin Nadjafi DPM accept payment directly from my insurance company; I understand that I am responsible and liable for any and all deductible/co-pay expenses for the insurance company. If in the event Ramin Nadjafi DPM, DPM are required to retain the services of an attorney/collection agency to collect his bills I agree to pay Ramin Nadjafi DPM fees up through and including appellate fees.

A copy of our office's Privacy Practices is available from the front desk upon request.

_____ (SIGNATURE) _____ (DATE)