

**Adler Podiatry Clinic, PLLC**

**Patient Information**

Date: \_\_\_\_\_ Referring Doctor \_\_\_\_\_ Dr's Phone Number \_\_\_\_\_

Patient's Name \_\_\_\_\_  
(LAST) (FIRST) (MI)

Home Address \_\_\_\_\_ Apt # / Lot \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_ E-Mail \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Social Security Number \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Employed by \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

**Financially Responsible Party (Spouse/Parent) Information**

Name \_\_\_\_\_  
(LAST) (FIRST) (MI)

Social Security Number \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Employed by \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Insurance Information**

Primary Insurance \_\_\_\_\_ Primary Card Holder Name \_\_\_\_\_

Plan:  Aetna  BC/BS  Cigna  Medicare  United HealthCare  Tricare

Secondary Insurance \_\_\_\_\_ Primary Card Holder Name \_\_\_\_\_

Plan:  Aetna  BC/BS  Cigna  Humana  Medicare  United HealthCare  Tricare

**(Please Read and Sign Back Page)**

**Adler Podiatry Clinic, PLLC**

**For Office Use:** Account Number:.....

**AUTHORIZATION FOR RELEASE OR RECEIPT OF MEDICAL INFORMATION**

**AND**

**AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**

I hereby grant Adler Podiatry Clinic, PLLC the authority to seek, receive, release, or transmit any and all information pertaining to me as may be necessary to process my insurance claim(s) and to bill and receive payment from my insurance company for any and all services rendered to me by Adler Podiatry and Wound Care, LLC or its designees.

I hereby agree to pay Adler Podiatry Clinic, PLLC in a timely fashion, for any and all services rendered which may or may not be covered by my insurance. This includes all co-payments and/or insurance payments that I may receive as a result of services rendered by Adler Podiatry Clinic, PLLC. In the event that a collection service is required to collect any unpaid balance, I agree to pay any additional costs which may be applied by the collection service.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_

(Relationship if other than patient) \_\_\_\_\_

**FOR OFFICE USE**

COPY OF DRIVER'S LICENSE AND INSURANCE CARD