Pinnacle Peak Podiatry, PLLC

Patient Information

Today's Date: _____ Date of Birth: _____

Patient's Name: _____ Phone: ( ) Cell _____
First (MI) Last (check preferred) ( ) Home _____

Address: _____ Ethnicity: Asian Caucasian
Latino African-american
Other _____
(circle one)

Patient's Employer: _____ Work Phone: _____

Social Security #: _____ Sex: Male _____ Female _____ Age: _____ Marital Status: M S D W O

Responsible Party (parent): _____ Relation: _____ DoB: _____ SS#: _____

Emergency Contact: _____ Relation: _____ Telephone #: _____

May we leave a message regarding medical care, billing or other issues? ( ) Yes ( ) No

I authorize the release of medical information to: _____

Primary Care Physician: _____ Phone #: _____ Were you referred? _____

How did you hear about our office? _____

Email address: _____

Pharmacy: _____ Pharmacy Phone: _____

Pharmacy Address or Cross Streets: _____

Insurance Information (Please complete all insurance information)

Primary Insurance Information

Insurance Name: _____

Policy Holder: _____ DoB: _____

ID #: _____ Group #: _____

Employer: _____

Secondary Insurance Information

Insurance Name: _____

Policy Holder: _____ DoB: _____

ID #: _____ Group #: _____

Employer: _____

Is this a work related injury? _____ If yes, date of injury: _____ Carrier: _____

Claim #: _____ Adjuster: _____ Telephone #: _____

Assignment of Benefits: I authorize the release of information necessary to process this claim and hereby assign my insurance benefits to be paid to Pinnacle Peak Podiatry, PLLC (Cathleen A. McCarthy, DPM). I understand my insurance company may assist me in paying my medical costs, but I am ultimately responsible for all medical services rendered and, if necessary, I agree to pay all reasonable and customary collection fees and/or attorney's fees that may be incurred due to any delinquent accounts I may have. I understand that I am financially responsible for my bill.

Medicare/Medigap Authorization: I request payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Pinnacle Peak Podiatry, PLLC (Cathleen A. McCarthy, DPM) for any services furnished to me by that provider.
To the extent permitted by law, I authorize any holder of medical or other information about me be released to the Centers for Medicare and Medicaid Services, My Medigap insurer, and their agents any information needed to determine these benefits for related services.

_____ _____
Signature of Patient, Beneficiary, Guardian or Personal Representative Relationship to Patient

_____ _____
Please print name Date