

# Pinnacle Peak Podiatry, PLLC

## Patient Information

Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
First (MI) Last

Phone: ( ) Cell  
(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: \_\_\_\_\_

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

Claim #: \_\_\_\_\_ Adjuster: \_\_\_\_\_ Telephone #: \_\_\_\_\_

### Secondary Insurance Information

Insurance Name: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ DoB: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Employer: \_\_\_\_\_

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