PATIENT INFORMATION

Patient's Name (Last, First):_____Date of Birth:_____
Name you prefer to be called (Mr. Smith, Mrs. Jones, Bob, etc):_____Sex: □ M □ F
Language_____Race_____ Ethnicity □_____
Patient's Address:_____
City, State, Zip:_____ E-mail address:_____
Home Phone Number:_____Cell Phone Number:_____
Social Security #:_____Driver's License #:_____
Employment Status □ Employed □ Unemployed □ Student □ Retired □ Child
If contacting you by phone for test results, is it okay to leave results on voicemail? □ yes □ no
How did you hear about our practice/ whom may we thank for referring you?_____

SPOUSE/ PARENT/ GUARDIAN INFORMATION

Name (Last, First):_____ Date of Birth:_____
Home Phone Number:_____Cell Phone Number:_____

EMERGENCY CONTACT (If Different from Guarantor)

Name_____Relationship:_____
Phone #:_____

INSURANCE INFORMATION

Primary Carrier Name:_____Primary Carrier Phone #:_____
Member's Name (if not patient):_____Relationship:_____
Member ID #:_____
Secondary Carrier Name:_____Secondary Carrier Phone #:_____
Member's Name (if not patient)_____Relationship:_____
Member ID #:_____

PHARMACY INFORMATION

Pharmacy Name_____Phone #:_____
Address:_____
City, State, Zip:_____

I hereby authorize Dr. Charles Baik and his associates to examine, photograph, administer treatment, and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot/ankle problem.

I assign the right to payment for all medical benefits directly to Dr. Charles Baik in consideration for medical services and supplies provided pursuant to my health insurance plan.

I give consent to Dr. Baik to release medical information to other healthcare providers for the purpose of treatment, when necessary for my care. I give consent to Dr. Baik to send medical information, as necessary to my insurance plan. I agree that a photo copy of this form may be used in lieu of the original.

I certify the patient information form is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature:_____ Date:_____
If Legal Representative, Relationship to Patient:_____