Patient Information Sheet

Patient information:

Last name:

First name:

MI:

Sex: ☐ Male ☐ Female

Address:

Apt.:

City:

State: Zip:

Social Security #:

Home phone:

Date of birth:

Work Phone:

Occupation:

Cell Phone:

Email:

Emergency Ph:

Contact Name:

Language:

Race:

Smoking Status: ☐ Yes ☐ Past ☐ Never ☐ Occasionally

Ethnicity:

Referred by:

Physician:

Pharmacy:

Address / City:

Guarantor: (responsible person if different form patient)

Last name:

First name:

Address:

Apt.:

City:

State: Zip:

Home phone:

Work phone:

Sex: ☐ Male ☐ Female

Date of birth:

Employer:

Address:

City:

State: Zip:

☐ **I am the legal representative of the patient named above.**

Authorization for Medical Examination and Treatment:

I give permission to Dr. Frank J. Brady, Jr. to examine and administer treatment. He may perform such procedures that may be deemed necessary in the diagnosis and treatment of my foot and/or leg condition.

Signature: Date:

Insurance Information

Primary Plan:

Card holder:

Relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other

ID #

Group #

Secondary Plan:

Card holder:

Relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other

ID #

Group #

Other Plan:

Card holder:

Relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other

ID #

Group #

Patient's or Authorized Person's Signature

Does your insurance carrier require a referral?

☐ **Yes** ☐ **NO**

The patient is always responsible for obtaining their referral. Non-compliance is no excuse for no-payment.

I request payment for authorized medical insurance benefits listed above (Medicare, Blue Shield etc.) be made to me or on my behalf to Dr. Frank J. Brady, Jr., for any services furnished me by that physician. I authorize the release of any medical information necessary to process my claims to the above named insurance programs.

Signature: Date: