DATE____________________ Pt# ____________________

XRAY # ____________________

PATIENT NAME ____ BIRTHDATE _____/_____/_____ AGE_____
(LAST) (FIRST) (MI)

MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED ☐

ADDRESS ____
(NUMBER & STREET) (APT NO.) (CITY) (STATE) (ZIP)

PHONE# (________)________________________________ PATIENT'S SSN# _______ - _______ - _______

PATIENT OCCUPATION ______________________________ EMPLOYER ______________________________

EMPLOYER'S ADDRESS ____________________________________ PHONE ____________________

NAME OF SPOUSE/PARENT __________________________________ RELATIONSHIP ____________________

EMERGENCY CONTACT: ____
(NAME & RELATIONSHIP TO PATIENT) (PHONE NUMBER)

- -

MEDICAL INSURANCE COMPANY ____

POLICY HOLDER'S NAME ____

POLICY HOLDER'S PLACE OF EMPLOYMENT (IF OTHER THAN PATIENT'S) ______________________________

BIRTHDATE & SSN# OF POLICYHOLDER ____
(IF OTHER THAN THE PATIENT) (BIRTHDATE) (SOCIAL SECURITY NUMBER)

- -

HT______________ WT______________ YOUR HEALTH IS: Good____ Fair____ Poor____

EXPLAIN PRESENT FOOT PROBLEM ____

HOW DID YOU HEAR OF OUR OFFICE? ____

- -

Please be advised that if your current insurance policy is considered out-of-network, any co-pays and/or deductibles that may be applied by your insurance becomes the responsibility of the patient or policy holder.

____
(SIGNATURE OF PATIENT)

I HEREBY GIVE PERMISSION FOR DR. BRUCE MEYERS TO ADMINISTER TREATMENT.

______________ ____
DATE SIGNATURE OF PATIENT

______________ ____
DATE PARENT OR GUARDIAN (IF PATIENT IS A MINOR)

PLEASE SIGN INSURANCE AND X-RAY POLICY ON BACK