Dr. Pinsker & Staff Welcome You to Our Office

Patient: _____ Date _____
(First) (MI) (Last)

Social Security # _____ Date of Birth _____ Age _____

Gender F M Marital Status S M W D

Patient Address: _____

City_____ Zip_____ Home Phone: _____

Cell Phone: _____ Work Phone:_____

E-Mail Address _____ **(We will only use E-mail addresses to contact you regarding issues related to your foot health)**

Chief Foot Complaint: _____

Former Podiatrist _____ Date Last Seen _____

Family Physician_____ Date Last Seen _____
(Diabetics must fill in this date)

Family Physician Phone # _____

Do you have diabetes? Yes No **Borderline diabetic?** Yes No **Last Blood Sugar**_____ **Date:** _____

I hereby give Permission to Dr. Philip S. Pinsker and/or associates to examine and medically treat my feet.

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Insurance Information

Only complete this section if you are not the policy holder

Policy Holder's name: _____

Relationship to patient: _____

Date of Birth _____

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Assignment & Release

I hereby authorize the processing of the medical insurance either by electronic or manual method by Philip S. Pinsker D.P.M. My signature below authorizes payment of all major medical and/or surgical benefits to which I am entitled from my insurer to pay to Philip S. Pinsker D.P.M. I further authorize assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation of any coinsurance or deductible and non-covered service that may be required. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as an original.

Patient's Signature **Or** **Responsible Party's Signature (If Minor) & print your relationship with patient** **Date**

_____ _____ _____