Patient's First Name _____Last Name _____

Home Address_____City_____State_____Zip_____

Home Phone ☐ (____)_____ Work ☐ (____)_____ __Cell ☐ (____)_____

Please indicate your number preference to confirm appointments.

Marital Status: (Please circle) S M Sep D W DP Sex: M or F

Date of Birth _____/_____/_____ *required* SS#_____/_____/_____

Email Address_____

Employer Name/Address_____Occupation_____

In addition to the information below - WE MUST HAVE A COPY OF YOUR INSURANCE CARD!

Primary Insurance_____Policy Holder's Name_____

Insured's DOB_____/_____/_____Sex: M or F Relationship ☐ Spouse ☐ Parent ☐ Other_____

Secondary Insurance_____Policy Holder's Name_____

Insured's DOB_____/_____/_____Sex: M or F Relationship ☐ Spouse ☐ Parent ☐ Other_____

If a patient is a MINOR, please provide name and address, (if different) of responsible party:

Name_____Address_____

REFERRED BY: Dr._____Friend_____Other_____

☐ **Website** ☐ **Insurance Company** ☐ **Sign** ☐ **Yelp** ☐ **Lecture** ☐ **Family** ☐ **I'm a prior patient**

Please Note- There is a $65.00 fee for any broken, missed, or cancelled appointments unless a 48 hour advance notice is given. **Patient Initials _____**

If you do not provide the correct insurance information at the time of your visit, we will be unable to bill your insurance and you will be responsible for your payment in full.

Co-payments are due at the time of service. We will bill all contracted insurance companies, however you are ultimately responsible for all charges whether or not paid by your insurance. For your convenience, we accept Cash, Checks, and Credit Cards. To avoid late payment fees or finance charges all unpaid balances are your responsibility within 30 days from the date of Service.

Dr.Robinson may inform your other physicians of your podiatric condition to facilitate continuity of care.

I here by assign and request that my insurance benefits be paid directly to Douglas Robinson DPM, PPC. I also authorize the office to release any information required to process my claim(s). A photocopy of this authorization shall be considered as effective and valid as the original. My signature below indicates that I have read, understand, and agree to the office policies. The HIPPA policy is available to review in the office and at my request a copy will be given to me to take home.

Signed_____Date_____

04.12.18