Tri-City Podiatry Group

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DEMOGRAPHICS

First Name:	M.I.:	Last Name:	Social Security#:

Reminder call for Appointments?	Date of Birth:	Sex:	Home Phone:	Cell Phone:
☐ Yes ☐ No		☐ Male ☐ Female		

Mailing Address:	Apartment#/Letter:	City:	State:	Zip Code:

Primary Care Physician:	Primary Care Phone#:	Previous Podiatrist:	Date of Last Visit:

Occupation:	Employer:	Email Address:

Emergency Contact Phone#:	Emergency Contact Name & Relation:	Preferred Pharmacy & Location:

PRIMARY INSURANCE

Insurance Company Name:	Type:	Subscriber/Insurance ID#:	Group#:
	☐ PPO ☐ EPO ☐ HMO ☐ Supplement		

SECONDARY INSURANCE

Insurance Company Name:	Type:	Subscriber/Insurance ID#:	Group#:
	☐ PPO ☐ EPO ☐ HMO ☐ Supplement		

TERTIARY INSURANCE

Insurance Company Name:	Type:	Subscriber/Insurance ID#:	Group#:
	☐ PPO ☐ EPO ☐ HMO ☐ Supplement		

ACKNOWLEDGEMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES AND OFFICE POLICIES

I or my Legal Guardian/Parent/Caregiver have received a copy of **Tri-City Podiatry Group**'s Notice of Privacy Practices effecive April 14th, 2003. I understand by signing this I am agreeing to Tri-City Podiatry Group's Office Policies and Notice of Privacy Practices.

OFFICE POLICIES

- I understand that I am responsible for my bill and paying my copay at the time of my visit.
- I authorize release of information and use of this form to all my insurance companies.
- I authorize my doctor to act as my agent in obtaining payment from my insurance company.
- I understand that I am responsible for updating the office of any insurance, address, or phone number changes.

Name (Print):	Signature:	Date:

Legal Guardian/Parent/Caregiver Name:	Legal Guardian/Parent/Caregiver Signature:	Date: