# PODIATRIC REGISTRATION AND HISTORY

## *1 PATIENT INFORMATION*

Name_______________________________________________

Address_____________________________________________

____________________________________________________
City State Zip

Home Phone ____________________________________

Mobile Phone ___________________________________

Best time and Place to reach you ____________________________

E-mail address (optional)____________________________________

Sex ☐M ☐F Age_____ Birth date____________________

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Soc. Sec. No.:_____________________________________

Occupation _______________________________________

Employer ________________________________________

Employer Address _________________________________

____________________________________________________
City State Zip

Employer Phone ___________________________________

Spouse's Name ____________________________________

Birth date _______________ SS# ________________________

Occupation _______________________________________

Spouse's Employer _________________________________

Whom may we thank for referring you?__________________________

Relationship ______________________________________

**IN CASE OF EMERGENCY, CONTACT**

Name _______________________ Relationship_______________

Home Phone_________________ Work Phone________________

## *2 INSURANCE INFORMATION*

Insurance Co. ______________________________________

Subscriber Name ___________________________________

Birth date: ____________________ SS# ____________________

Employer __________________________________________

Address ___________________________________________

Relationship to Patient _____________________________

Contract# ________________________ Group # ____________

Appointment Date _______________________________

Is the patient covered by **additional** insurance?
☐Yes ☐No If yes, please fill in the following:

Subscriber Name ________________________________

Birth date________________ SS#_________________

Relationship to Patient ___________________________

Insurance Co. ___________________________________

Contract#______________________ Group # _________

Who is your Primary Care Physician? (first & last name)

_______________________________________________

Phone ___________________________________________

**ASSIGNMENT AND RELEASE**

I, the undersigned certify that I (or my dependent) have insurance coverage with ___________________________ and assign directly to Dr. David Velarde all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____________________________________________________
Responsible Party Signature

____________________________________________________
Relationship Date

**MEDICARE AUTHORIZATION**

I request payment of authorized Medicare benefits be made either to me or on my behalf to Dr Velarde for services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature request that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

____________________________________________________
Beneficiary Signature Date

David M. Velarde, DPM • 2824 Merchants Dr • Knoxville, Tn 37912
*Specializing in Podiatric Medicine* • phone: (865) 523-1141 • fax: (865) 521-6635