PARNASSUS HEIGHTS PODIATRY GROUP

A Professional Corporation

Diseases & Injuries of the Foot & Ankle

Joel R. Clark, DPM • Jamie Kim, DPM • Colin J. Traynor, DPM

PATIENT INFORMATION

Last: _____ First: _____ MI: _____

Nickname/Preferred Name: _____

Address: _____ Unit: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SSN: ____ - ____ - ____ Email: _____

Sex (M or F): _____ Date of Birth: _____ Age: _____

Employer: _____ Occupation: _____

INSURANCE & BILLING

Primary Insurance: _____ Secondary Insurance: _____

Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Other Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Subscriber Name: _____ Subscriber Name: _____

Subscriber DOB: _____ Subscriber DOB: _____

If patient is under 18, please provide the person responsible for billing:

Name: _____ Phone: _____

Address: _____ Relation to Patient: _____

EMERGENCY CONTACT

Name: _____ Phone: _____

Relation to Patient: _____

MEDICAL INFORMATION

Referring Doctor/Primary Care Physician: _____

PCP Phone: _____ Date Last Seen: _____

Pharmacy Name/Location: _____ Pharmacy Phone: _____

Have you ever seen a podiatrist? ☐ No ☐ Yes If yes, who and when? _____

INSURANCE AUTHORIZATION & ASSIGNMENT

I hereby authorize Parnassus Heights Podiatry Group to furnish information to insurance carriers concerning my illnesses and treatments and to my referring physician if so requested. I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Signature: _____ Date: _____

Please initial if you will allow photographs to be taken of your feet for educational purposes only. _____

Thank you!

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