

**Jeffrey S. Stevens D.P.M.**

# PATIENT INFORMATION

DATE \_\_\_\_\_

Referring Physician \_\_\_\_\_

PATIENT'S NAME LAST FIRST M.I.			HOME PHONE NO.		BUSINESS PHONE NO.	
STREET ADDRESS				DATE OF BIRTH	AGE	SOCIAL SECURITY NO.
CITY		STATE	ZIP CODE	MARITAL STATUS _____S _____M _____W _____D _____SEP		
EMPLOYER'S NAME (INDICATE IF STUDENT)			EMPLOYER'S ADDRESS			ZIP CODE
SPOUSE'S NAME LAST FIRST M.I.			DATE OF BIRTH		SOCIAL SECURITY NO.	
SPOUSE'S EMPLOYER			OCCUPATION		BUSINESS PHONE NO.	
EMPLOYER'S STREET ADDRESS				CITY AND STATE		ZIP CODE
PERSON RESPONSIBLE FOR PAYMENT LAST FIRST M.I.				ADDRESS		HOME PHONE NO.
EMERGENCY CONTACT (NOT LIVING WITH YOU) LAST FIRST M.I.			RELATION	ADDRESS		HOME PHONE NO.
<b>IF THE PATIENT IS A MINOR OR A STUDENT</b>						
MOTHER'S NAME LAST FIRST M.I.			LEGAL GUARDIAN ____YES ____NO	STREET ADDRESS, CITY, STATE AND ZIP CODE		HOME PHONE NO.
MOTHER'S EMPLOYER			OCCUPATION	SOCIAL SECURITY #	BUSINESS PHONE NO.	
EMPLOYER'S ADDRESS				CITY AND STATE		ZIP CODE
FATHER'S NAME LAST FIRST M.I.			LEGAL GUARDIAN ____YES ____NO	STREET ADDRESS, CITY STATE AND ZIP CODE		HOME PHONE NO.
FATHER'S EMPLOYER			OCCUPATION	SOCIAL SECURITY #	BUSINESS PHONE NO.	
EMPLOYER'S STREET ADDRESS				CITY AND STATE		ZIP CODE
DO YOU HAVE AN ADVANCE DIRECTIVE? YES___ NO___ IF YES YOU HAVE THE RIGHT TO HAVE IT BECOME A PART OF YOUR MEDICAL RECORD. PLEASE PROVIDE IT TO THIS OFFICE. WOULD YOU LIKE INFORMATION ABOUT ADVANCED DIRECTIVES YES___ NO___. INFORMATION PROVIDED TO PATIENT_____ BY _____						
<b>INSURANCE INFORMATION (PLEASE SHOW IDENTIFICATION CARD(S) TO RECEPTIONIST)</b>						
PRIMARY INSURANCE CO.				POLICY HOLDER		DATE OF BIRTH
SECONDARY INSURANCE CO.				POLICY HOLDER		DATE OF BIRTH

**INSURANCE AUTHORIZATIONS:**

I HEREBY AUTHORIZE ANY INSURANCE COMPANY TO PAY THE PROCEEDS OF ANY ASSIGNED BENEFITS DIRECTLY TO JEFFREY S. STEVENS D.P.M. I AUTHORIZE JEFFREY S. STEVENS D.P.M. TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS ON MY BEHALF. A COPY OF THIS CAN BE CONSIDERED AS AN ORIGINAL FOR INSURANCE PURPOSES.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

I UNDERSTAND I AM RESPONSIBLE FOR MEETING THE REQUIREMENTS OF MY INSURANCE POLICY. I UNDERSTAND ANY CHARGES NOT PAID BY MY INSURANCE ARE MY RESPONSIBILITY AND WILL BE RESPONSIBLE FOR ANY COLLECTION OR LEGAL FEES NECESSARY TO COLLECT SAID CHARGES.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_