



Desert Foot Surgeons

**Patient Information (please print)**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
street city, state, zip

SSN # \_\_\_\_\_ Ht \_\_\_\_ Wt \_\_\_\_ Shoe size \_\_\_\_\_ Cell phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Relation to insured (circle one): self / spouse / child Sex (M/F) Email \_\_\_\_\_

Spouse / Parent / Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

**Insurance Information**

Primary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Grp # \_\_\_\_\_

Claims address \_\_\_\_\_ Phone \_\_\_\_\_

Policy holder name \_\_\_\_\_ Relation \_\_\_\_\_

SSN# of Policy holder \_\_\_\_\_ Date of birth of policy holder \_\_\_\_\_

Policy holder Employer \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Grp # \_\_\_\_\_

Address to send claims \_\_\_\_\_ Phone \_\_\_\_\_

Policy holder name \_\_\_\_\_ Relation \_\_\_\_\_

SSN # of Policy holder \_\_\_\_\_ Policy holder date of birth \_\_\_\_\_

After receiving all of the current and necessary insurance information from you, we will be happy to bill your insurance company/companies on your behalf.

**Please review the following, sign and date below:**

I understand that I am responsible for any and all charges that my insurance deems "patient responsibility". I understand that I am responsible for any and all charges that are denied by my insurance due to lack of accurate insurance information provided by me. I authorize release of information for insurance purposes concerning treatment of the above named patient while under your care. I authorize payment of any insurance benefits for medical or surgical services. I authorize use of my signature for all insurance submissions.

**If my insurance requires a referral or authorization, I understand that it is my responsibility to make sure that I have a valid referral on file for the date that services are rendered. If I do not have a referral or if my referral is not valid, I understand that I will be fully responsible for payment.**

Signature \_\_\_\_\_ Date \_\_\_\_\_