H. H. Nuss, D.P.M., P.C.
Patient Information Sheet

Patient Information:

Patient Name _____

Street Address _____

City/State/Zip: _____

Sex: _____ Home Phone: _____

Work Phone: _____ Extension: _____

Date of Birth: _____ Soc Sec #: _____

Marital Status: _____ Referred By: _____

Resp Party Info: (If other than patient)

Resp Party Name: _____

Resp Party Address: _____

City/State/Zip: _____

Relation to Patient: _____ Date of Birth: _____

Home Phone: _____

Work Phone: _____ Extension: _____

Patient Insurance:

Primary Insurance Name: _____ Ins Phone #: _____

Subscriber/Policy #: _____

Group #: _____ Plan #: _____ Copay Amount: $ _____

Policy Holder Name: _____ PolicyHolder Employer: _____

Patient Relation to PolicyHolder: _____ PolicyHolder SS#: _____

Secondary Insurance Name: _____ Ins Phone #: _____

Subscriber/Policy #: _____

Group #: _____ Plan #: _____ Copay Amount: $ _____

Policy Holder Name: _____ PolicyHolder Employer: _____

Patient Relation to PolicyHolder: _____ PolicyHolder SS#: _____

Employer Information:

Patient Employer: _____ Phone: _____ Extension: _____

Patient Employer Address: _____

_____

Emergency Contact Information:

Emergency Contact:

Name: _____ Home Phone: _____

Relation to Patient: _____ Work Phone: _____

I authorize my insurance company to pay benefits directly to my physician. I hereby consent to the release of medical information necessary to process any insurance claims and to any other doctor for the continuation of my medical care. I accept personal responsibility for any and all services in which I have been proven ineligible for medical benefits. I understand that a photo-copy of this release is as valid as the original.

Patient Signature: _____ _____

(If patient is under 18 this must be signed by parent or guardian) Date