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

Patient Information:

Patient Name _____

Street Address _____

City/State/Zip: _____

Sex: _____ Cell Phone: _____

Work Phone: _____ Extension: _____

Date of Birth: _____ Soc Sec #: _____

Marital Status: _____ Email: _____

Resp Party Info: (If other than patient)

Resp Party Name: _____

Resp Party Address: _____

City/State/Zip: _____

Relation to Patient: _____ Date of Birth: _____

Cell Phone: _____

Work Phone: _____ Extension: _____

Name, Number & Address of Preferred Pharmacy:

Preferred Pharmacy Name: _____ Phone #: _____

Address: _____

_____

Patient Insurance:

Primary Insurance Name: _____ Ins Phone #: _____

Subscriber/Policy #: _____

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

Secondary Insurance Name: _____ Ins Phone #: _____

Subscriber/Policy #: _____

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

Employer Information:

Patient Employer: _____ Phone: _____ Extension: _____

Patient Employer Address: _____

_____

Emergency Contact Information:

Emergency Contact:

Name: _____ Cell 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.

_____ _____

Signature (Patient or parent if under 18 years of age) Date