

Patient Information : (Please note, this form must be completed once each year.)

Last Name:	Secondary Insurance Name:
First Name, Middle Initial:	Secondary ID#:
Home Address: (P.O. Boxes not accepted)	Secondary Group#:
City, State, Zip:	Secondary Policy Holder:
Home Phone:	Secondary Policy Holder SS#:
Work Phone:	Secondary Policy Holder DOB:
Cell Phone:	Relationship: Circle: Self or Spouse or Child or Other
Social Security #: (required)	Secondary Policy Holder Sex: Circle Male or Female
Sex: Circle Male or Female	***Primary Care Physician***:
Email Address:	Address:
Date of Birth:	City State, Zip:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Phone and Fax #s:
Primary Insurance Name:	***Referring Physician***:
Primary ID#:	Phone and Fax #'s:
Primary Group#:	Emergency Contact & #'s:
Primary Policy Holder:	Relationship:
Primary Policy Holder SS#:	***Primary Pharmacy***:
Primary Policy Holder DOB:	Location:
Relationship: Circle: Self or Spouse or Child or Other	Phone & Fax #s:
Primary Policy Holder Sex: Circle Male or Female	***How did you hear about us?***

Patient Combined Consent Form for Insurance and Office Policies

I certify that the information I have provided regarding my insurance coverage is correct and I authorize the office of Wiener & Daniels, DPM, PA to verify my insurance coverage and benefits allowed in accordance with my insurance plan's policies. I authorize that payments be made directly to Wiener & Daniels, DPM, PA for all medical benefits which are payable under the terms of my insurance policy for the services provided. I agree to pay any co-payments, co-insurance, or deductible as required by my insurance plan for medical care provided to me or my dependent. I understand that I am responsible for knowing the terms and regulations of my insurance plan, and that specialist referrals are my responsibility at all times. I agree to accept full responsibility for payment if my insurance coverage is interrupted or terminated during my care.

I authorize Wiener & Daniels, DPM, PA to submit a claim to my insurance company, health and welfare fund, Medicare or Medicaid (or Medical Assistance program) for medical service provided to me or my dependent. I authorize release of any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit, including outside vendors that may be used on my behalf for surgical procedures, wound care, that provide services or durable medical equipment for said surgical procedures or equipment.

I agree to pay for medical services provided to myself or my dependent which are not covered by the benefits of my insurance plan. I agree to the above stated responsibility and consent:

Receipt of Notice of Privacy Practices Acknowledgement

I certify that I have been given access to a copy of Wiener & Daniels, DPM, PA's Notice of Privacy Practices.

Receipt of Office and Financial Policies

I have received a copy of Wiener & Daniels, DPM, PA's Office and Financial Policies and understand them as stated. I agree to abide by Wiener & Daniels, DPM, PA Office and Financial policies.

Consent for Release of Medical Information

The office of Wiener & Daniels, DPM, PA is authorized to discuss my medical information, including test results, medications, appointment times, and both insurance and billing information, with the following individuals only. I understand that without prior consent, and without exception, and for my protection, my medical information will not be shared otherwise.

Name	Relationship	Phone #

Name of Patient

Date of Birth

Signature of Patient or Guardian

Date