

Advanced Foot Care Center of Rochester New Patient Financial Policy

Patient's
Last name _____ First _____ Home Phone _____ Cell Phone _____
Home Address _____ City _____ Zip _____ How Long? _____
Previous Address if less
Than 3 Years _____ City _____ Zip _____
Driver's License No. _____ Birthdate _____ Age _____ SS# _____
Employer _____ Address _____

Spouse Information

Spouse's Name _____ Occupation _____ Years There _____
Spouse's Employer _____ Phone _____ Ext _____
Employer's Address _____ City _____ Zip _____

Relative Emergency Contact Information

Nearest Relative Not Living With you _____ Home Phone _____ Work (Cell) Phone _____
Who may we contact in case of emergency that does not reside with you? _____ Phone _____

Physician Information

Primary Physician _____ Date of Last Physical _____ Date of Last Visit _____

Referral Information

Who may we thank for referring you to us? _____

Insurance Information

Medical Insurance Yes No If Patient is a Minor, Financial Responsible Party _____
Relationship to Patient _____ Social security # _____
Blue Shield Preferred Care
Medicare Other _____
Medicaid Subscriber Name _____ Subscriber Number _____

I hereby give permission to Dr J. G. DiPrima, DPM to administer treatment and to perform such minor procedures as may be deemed necessary in diagnosis and/or treatment of my foot condition. In signing I guaranteeing payment for services and treatments rendered.

Date _____ Signature _____
(Parent If Minor)