Date_____________

***Please fill out Sections 1 and 3. If Patient is a dependent fill out Sections 1, 2, and 3.

Section 1.

Patient Name____ Date of Birth_________

Address_______________________________________City______________State_________Zip______________

Telephone Number_____________________________Cell Phone Number______________________Age_______

SSN#_______________________________ Male___ Female___ Married___ Single___ Divorced___ Widowed___

Patient's Employer__________________________________ Work #___________________________Ext._______

Name of Spouse____________________________________ Spouse's SSN#_______________________________

Spouse's Date of Birth___________________________ Spouse's Employer________________________________

Spouse's Work #________________________________ Ext.________________________

Emergency Contact____Phone Number____________________

Section 2. **COMPLETE IF PATIENT IS A DEPENDENT**

Father's Name _____________________________________ Mother's Name______________________________

Employer____ Employer___________________________________

Work #____ Work #_____________________________________

SSN#___________________________DOB____________ SSN#_____________________DOB____________

IF DEPENDENT IS A STUDENT

Name of School_________________________________College_______________________#hours____________

Section 3.

Whom should we thank for your appointment?____

Primary Care Dr.__________________________Phone_________________________FAX___________________

If you are diabetic or have PVD, name of treating Dr.____

Phone____________________________FAX______________________Drug Allergies______________________

Type of foot problem____

If due to injury – Date of injury______________________________ Where occurred_________________________

Explain the injury____

DOES YOUR INSUREANCE REQUIRE A REFERRAL FROM YOUR PRIMARY CARE DR.?

I GIVE MY PERMISSION FOR DR. JACOBS/DR. BERNIE TO EXAMINE AND TREAT ME OR MY DEPENDENTS. I UNDERSTAND RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ALL CLAIMS AND I REQUEST THE PAYMENT OF ALL INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN SUPPLYING THE SERVICE.

IF MY INSURANCE REQUIRES A REFERRAL AT ANY TIME DURING THE COURSE OF MY TREATEMENT AND WAS NOT OBTAINED, I AM RESPOINSIBLE FOR ALL CHARGES AND WILL MAKE PAYMENT IN FULL ON THE DAY OF SERVICE.

Signed____Relationship to Patient______________________

Witness____Date_____________________________________

**PLEASE PRINT THIS PAGE AND BRING WITH YOU TO YOUR APPOINTMENT**