# WELCOME TO STEP AHEAD PODIATRY.

Answer the following questions and bring with you to your appointment. Please know that all information is strictly confidential. Thank you for choosing our office and get in touch with any questions.

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**Patient Name** ______________________________ **Date of Birth** ___/___/___

**Home Address** ______________________ **City** ______________ **State** ________ **Zip** ________

**Home Phone (    )** ______________ **Cell Phone (    )** ______________ **Work Phone (    )** ______________

**Social Security #** ______________________ **Email Address** ______________________

**Age**________ **Sex:** ❑ *Male* ❑ *Female* **Marital Status:** ❑ *Single* ❑ *Married* ❑ *Divorced* ❑ *Widowed*

**Employer Occupation** ______________________________

**Race:** ❑ *White* ❑ *Black/African American* ❑ *American Indian* ❑ *Asian* ❑ *Native Hawaiian*

**Ethnicity:** ❑ *Hispanic/Latino* ❑ *Non Hispanic/Latino*

**Spouse/Parent/Guardian Name** ______________________________ **Phone (    )** ______________

**Emergency Contact Person Name** ______________________________ **Phone (    )** ______________

**Primary or Referring Physician Name** ______________________________ **Phone (    )** ______________

**Address** ______________________ **City** ______________ **State** ________ **Zip** ________

**Who referred you to our office?** ❑ *Doctor* ❑ *Family/Friend* ❑ *Online Search* ❑ *Website* ❑ *Yellow Pages* ❑ *Office* ❑ *Other*

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**1 – Primary Insurance** ______________ **ID/Contract #** ______________ **Group #** ___/___/___

**Policy Holder Relationship to Patient** ______________________ **Date of Birth** ______________

**2 – Secondary Insurance** ______________ **ID/Contract #** ______________ **Group #** ___/___/___

**Policy Holder Relationship to Patient** ______________________ **Date of Birth** ______________

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***It is your responsibility to inform us of any changes in your insurance. Failure to do so many result in claims not being paid and you being billed for the entire balance. If your insurance requires a referral to see a specialist this is your responsibility to provide one or you will be billed for the entire visit.***

**Assignment and Release**: I, the undersigned, certify that I (or my dependant) have insurance coverage with the above plan(s) and hereby assign all insurance benefits, if any, otherwise payable to me, directly to Step Ahead Podiatry for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I also authorize the doctor to release all information necessary to secure the payment of benefits from my insurance company.

**Consent for Treatment**: I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet:

**Patient/Guardian Signature** ______________________________ **Date** ______________