DR.ROBERT A. IRWIN,D.P.M, D.A.B.P.M

WELCOME TO OUR OFFICE PODIATRIC REGISTRATION AND HISTORY

PATIENT INFORMATION (Please print clearly)

NAME:_____ DATE OF BIRTH:_____AGE:_____Male/Female

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

SOCIAL SECURITY #:_____-____-_____ (PLEASE CIRCLE) SINGLE/MARRIED/DIVORCED/WIDOWED

HOME #:_____CELL#:_____WORK#:_____

EMAIL:_____EMERG.CONTACT:_____PHONE#:_____

REASON FOR PODIATRIC VISIT:_____

PRIMARY CARE PHYSICIAN:_____

PHONE#:_____FAX#:_____**LAST VISIT DATE**:_____

ADDRESS:_____CITY:_____STATE_____ZIP_____

REFERRED BY:_____

INSURANCE INFORMATION (Please print clearly)

Please note: If you fail to provide the correct insurance information at the time of your visit, we will be unable to bill your insurance company. You will then be responsible for payment, in full, at the time of the visit.

PRIMARY INSURANCE NAME:_____ID#_____

POLICY HOLDER'S NAME_____INSURED DATE OF BIRTH_____

RELATIONSHIP: (PLEASE CIRCLE) SELF/SPOUSE/PARENT/OTHER

SECONDARY INSURANCE NAME:_____ID#_____

POLICY HOLDER'S NAME_____INSURED DATE OF BIRTH_____

PHARMACY NAME/ADDRESS/PHONE#_____

INSURANCE AUTHORIZATION AND ASSIGNMENT: Co-payments are due at the time of service. We will bill all contracted insurance companies; however, you are ultimately responsible for all charges whether or not paid by your insurance company. I hereby authorize ROBERT A. IRWIN, DPM, PC to disclose my individually identifiable health information to the insurance carrier(s). Robert A. Irwin, DPM, PC will use and disclose my health information in order to obtain payment to the doctor for services rendered and allow insurance companies to process the claims. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal state law.

X_____ _____

Patient /Guardian/Insured Signature Date