

# PATIENT INFORMATION

In order to see you we must have a copy of your driver's license and your valid insurance card(s). Please print the following information. Payment is expected at time of service. All information will be confidential.

Date \_\_\_\_\_ Patient name \_\_\_\_\_  
SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Male  Female Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_ - \_\_\_\_\_  
Check appropriate box:  Minor  Single  Married  Divorced  Widowed  
Patient or parent/guardian employer \_\_\_\_\_ Work # ( ) \_\_\_\_\_ - \_\_\_\_\_  
Business address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Spouse or parent/guardian name \_\_\_\_\_ Work phone ( ) \_\_\_\_\_ - \_\_\_\_\_  
Emergency contact: Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

**How did you hear about us?**  Phonebook  Insurance plan  Hospital: Name \_\_\_\_\_  
 Sign in lobby  Retail store  Internet  Other advertisement  Other: \_\_\_\_\_  
 Friend: Name \_\_\_\_\_  Referring Physician: \_\_\_\_\_

## **Minors Responsible Party Information (full time students or people under the age of 18 only):**

Name of person responsible for this account \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ Home phone ( ) \_\_\_\_\_ - \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Cell phone ( ) \_\_\_\_\_ - \_\_\_\_\_  
Employer \_\_\_\_\_ Work phone ( ) \_\_\_\_\_ - \_\_\_\_\_

## **Primary Insurance Policy Information:**

Ins Co Name \_\_\_\_\_ Ins ID # \_\_\_\_\_  
Policy holders name \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer name \_\_\_\_\_

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*Do you have any additional insurance?*  Yes  No *If yes, complete the following:*

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## **Secondary Insurance Policy Information:**

Ins Co Name \_\_\_\_\_ Ins ID # \_\_\_\_\_  
Policy holders name \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer name \_\_\_\_\_

## **Financial Arrangements:**

*Payments of deductible, co-pay and co-insurance are expected at time of service. For your convenience we offer the following methods of payment only. Please mark one:*

Cash  Personal check  Visa  MasterCard  Discover  
 I may need to set up a payment plan  I wish to discuss the payment policy

## **Authorization and Release:**

I authorize release of my information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to **Treasure Valley**

**Podiatry/Podiatry Center of Idaho.**

X \_\_\_\_\_  
Signature of patient of parent/guardian of minor

\_\_\_\_\_  
Date