JAMES C RICKETTI DPM

PATIENT #_____ **TODAY'S DATE**_____

PATIENT INFORMATION SHEET

(PLEASE COMPLETE ALL APPLICABLE INFORMATION)

LAST NAME_____**FIRST NAME/MI**_____

ADDRESS_____**CITY/STATE**_____**ZIP**_____

HOME#_____**CELL#**_____**WORK#**_____

DOB_____**AGE**_____**GENDER**_____ **SOCIAL SECURITY#** ___-___-____

EMAIL ADDRESS_____ **OCCUPATION**_____

MARITAL STATUS_____STUDENT_____

EMPLOYMENT: FULL-TIME PART-TIME UNEMPLOYED

EMPLOYER_____

ADDRESS_____CITY/STATE_____ZIP_____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT): PARENT/ SPOUSE/ OTHER

LAST NAME_____FIRST NAME_____

ADDRESS_____CITY/STATE_____ZIP_____

TELEPHONE#_____

PRIMARY CARE PHYSICIAN_____REFERRAL_____

ADDRESS_____CITY/STATE_____ZIP_____

DATE LAST SEEN_____

PRIMARY INSURANCE (PLEASE PROVIDE INFORMATION & COPY OF CARD)

INSURANCE COMPANY NAME_____

POLICY ID#_____GROUP#_____

SPECIALIST COPAY AMOUNT_____

SUBSCRIBER (IF OTHER THAN PATIENT): PARENT/ SPOUSE/ OTHER

LAST NAME_____FIRST/MI_____

ADDRESS_____CITY/STATE_____ZIP_____

DOB_____TELEPHONE#_____

SECONDARY INSURANCE

INSURANCE COMPANY NAME_____

POLICY#_____GROUP#_____

SUBSCRIBER (IF OTHER THAN PATIENT): PARENT / SPOUSE/ OTHER

LAST NAME_____FIRST NAME/MI_____

ADDRESS_____CITY/STATE_____ZIP_____

DOB_____TELEPHONE#_____

)TOR VEHICLE ACCIDENT_____ WORKER'S COMP._____ OTHER_____

DATE OF ACCIDENT:_____ CLAIM#_____(WE MUST HAVE BEFORE SEEN)

INSURANCE CO. TO BE BILLED_____

ADDRESS TO SEND BILLS_____

CITY_____STATE_____ZIP_____

PHONE#_____FAX#_____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I (print)_____ understand the Notice of Privacy Practices for this office.

YES _____ I choose to receive a copy of this notice.

_____

Signature Date

EMERGENCY CONTACT INFO

NAME:_____

HOME#_____CELL#_____

WORK#_____

RELATIONSHIP_____

PHARMACY NAME_____

STREET ADDRESS_____

CITY_____STATE_____ ZIP_____

PHONE #_____

I AUTHORIZE THE EXCHANGE OF MEDICAL AND INSURANCE INFORMATION TO OTHER PHYSICIANS AS NECESSARY FOR MY TREATMENT, CARE AND INSURANCE PROCESSING.

I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO MY INSURANCE CARRIERS FOR THE PROCESSING OF MY MEDICAL CLAIMS FOR PAYMENT TO ME OR DR. JAMES C. RICKETTI.

I AGREE TO PAY FOR APPOINTMENTS NOT CANCELLED 24 HOURS IN ADVANCE!!!

SIGNATURE_____**DATE**_____