

## Patient Information

Mr.  Mrs.  Ms  Child  Sex: M  F

Date: \_\_\_\_\_

Name, Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Extension: \_\_\_\_\_

Marital Status: Single: \_\_\_\_\_ Married: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer Name: \_\_\_\_\_ Your Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Guardian Information

Who is Financially Responsible? \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Extension: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Insurance Information

### PRIMARY INSURANCE

Insurance Carrier Name \_\_\_\_\_

Address \_\_\_\_\_

Insured Name \_\_\_\_\_

Policy # / Group # \_\_\_\_\_

SSN / ID # \_\_\_\_\_

Employer \_\_\_\_\_

### SECONDARY INSURANCE

Insurance Carrier Name \_\_\_\_\_

Address \_\_\_\_\_

Insured Name \_\_\_\_\_

Policy # / Group # \_\_\_\_\_

SSN / ID # \_\_\_\_\_

Employer \_\_\_\_\_

**WHEN REGISTERING, PLEASE PRESENT YOUR PROOF OF INSURANCE.  
PAYMENT IS EXPECTED AT THE TIME OF SERVICE.**

Payment is expected at the time of service. For those who are with a Management Care or PPO group, please know that in this era of multitudes of insurance plans, we cannot possibly be aware of each individual's insurance arrangement.

It is therefore your responsibility: 1) to make sure that we are currently acceptable providers for your insurance coverage, 2) to make sure that you are eligible for insurance benefits on services you are receiving from us, and 3) to notify us as to any precertification requirements for that coverage.

Again, though we certainly will assist you in obtaining payment from your insurance carrier, the ultimate responsibility for payment of any bills incurred at our office lies with the patient.

Whom May We Thank for Referring You? \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## AUTHORIZATION

I authorize payment of medical benefits directly to Peter G. Chioros, DPM. In the event this account is assigned to collection I agree to pay all costs of collection including reasonable attorney fees.

I authorize the release of any medical information necessary to process my bills. That would include insurance companies or its designates and would involve both electronic and manual methods for billing. I also authorize the release of any medical information that I have specifically given individual authorization for that may arise during my treatment.

I am aware that Peter G. Chioros, DPM may disclose pertinent health information about me when required to do so by federal, state, or local agencies. Peter G. Chioros, DPM may also disclose health information about me in response to a court or administrative order in response to a subpoena.

I acknowledge receipt of my notice of privacy practices for Peter G. Chioros, DPM.

Signature

Date