NEW PATIENT INFORMATION

Name:____
Last First M.I.

Address:____
Street Apt# City State Zip

Phone:______________ **Social Security #:**______________________ DL#:__________

E-Mail:____________________ **Date of Birth:**____________________ **Sex:**______

Occupation:____________________ **Employer:**____________________

Employer Address:____________________________________ **Phone:**______________
Street

____
City State Zip

Name of Spouse/Parent:____________________ **Employer:**____________________

Employer Address:____________________________________ **Phone:**______________
Street

____
City State Zip

NAME OF PRIMARY INSURANCE CO:
____________________ **Subscriber:**____________________ **DOB:**______________

ID#:____________________ **Policy/Group:**____________________

(Secondary):____________________ **Subscriber:**____________________ **DOB:**______________

ID#:____________________ **Policy/Group:**____________________

CHIEF COMPLAINT:

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Who referred you to this office?____________________________________

I consent to receive appointment reminders via: ☐ **Email only** ☐ **Text message only** ☐ **Both email and text message**

I hereby authorize Jeff Brooks, DPM, Andrew To, DPM and Oceanside Foot & Ankle Center to furnish my insurance company all information which said insurance company may request concerning my illness of injury. I hereby assign to Jeff Brooks, DPM, Andrew To, DPM, or Oceanside Foot & Ankle Center all payments to which I am entitled for medical and/or surgical expenses relative to the service reported for my illness or injury. I understand that I am financially responsible to said doctor for charges not covered by this assignment of benefits. A photocopy of this assignment is as valid as the original.

Patient Signature____________________________________ Date:____________________

Legal Guardian (if patient is a minor)____________________________ Date:____________________