PATIENT INFORMATION FORM – Office of Carmen Wong, DPM / Charles Hu, DPM / Glenn Weinraub, DPM

Patient's **FULL** Name:_____ Name we may call you:_____

Address:_____ City:_____ Zip:_____

HOME Phone Number:_____ **CELL** Phone Number:_____

Preferred Number: (circle one) HOME CELL WORK

Email address:_____
(Only if you wish to be included in patient portal, we do not share this information)

Date of Birth:_____ Age: _____ □ Single □ Married □ Widowed □ Divorced □ Other

Birth Sex: Male Female (circle one) Gender Identity: Male Female Trans Gender Queer Other (circle one)

- Occupation:_____ Employers Name:_____

  Work Address:_____ Work Phone:_____

- Emergency Contact Name: _____

  Emergency Contact Phone(s):_____
  Emergency Contact Relationship to patient: (circle one) Spouse Parent Child Friend

Information regarding person who is financially responsible for patient (if different than patient, such as parent/spouse/conservator): (copayments/co-insurance/deductibles/items not covered by health insurance)

Name: _____ Relationship:_____

Address:_____ City:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

- Who referred you to the office?_____
- Have you been treated by a podiatrist before? □ Yes □ No Podiatrist Name:_____
- What is your foot/ankle complaint?_____
- Name of your Primary Care Physician:_____
- Primary Language:_____
- Ethnicity: (circle one) Hispanic/Latino Not Hispanic/Latino Declined Unknown
- Race:(circle one) American Indian/Alaska Native Asian Black/African American Native Hawaiian/Pacific Islander White Other Declined

I hereby give my permission to Carmen Wong, DPM, and/or Charles Hu, DPM, and/or Glenn Weinraub, DPM to administer and treat with such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle condition. I hereby give authorization for payment of insurance benefits to be made directly to Vincent C Marino, DPM, Carmen Wong, DPM, and/or Charles Hu, DPM and/or any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I further agree that a photocopy of this agreement shall be valid as the original.

Signature:_____ Date:_____

Insurance Information (we must copy your insurance cards)

PRIMARY Insurance:_____ HMO/Medical Group:_____

ID#:_____ Group#:_____ Copayment:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

SECONDARY Insurance:_____ HMO/Medical Group:_____

ID#:_____ Group#:_____ Copayment:_____

Subscriber Name:_____ Subscriber Date of Birth:_____