

H. H. Nuss, D.P.M., P.C.
Patient Information Sheet

<u>Patient Information:</u>		Resp Party Info: (If other than patient)	
Patient Name _____		Resp Party Name: _____	
Street Address _____		Resp Party Address: _____	
City/State/Zip: _____		City/State/Zip: _____	
Sex: _____	Home Phone: _____	Relation to Patient: _____	Date of Birth: _____
Work Phone: _____	Extension: _____	Home Phone: _____	
Date of Birth: _____	Soc Sec #: _____	Work Phone: _____	Extension: _____
Marital Status: _____	Referred By: _____		

<u>Patient Insurance:</u>			
Primary Insurance Name: _____		Ins Phone #: _____	
Subscriber/Policy #: _____			
Group #: _____	Plan #: _____	Copay Amount: \$ _____	
Policy Holder Name: _____	PolicyHolder Employer: _____		
Patient Relation to PolicyHolder: _____	PolicyHolder SS#: _____		
Secondary Insurance Name: _____		Ins Phone #: _____	
Subscriber/Policy #: _____			
Group #: _____	Plan #: _____	Copay Amount: \$ _____	
Policy Holder Name: _____	PolicyHolder Employer: _____		
Patient Relation to PolicyHolder: _____	PolicyHolder SS#: _____		

<u>Employer Information:</u>			
Patient Employer: _____		Phone: _____	Extension: _____
Patient Employer Address: _____			

<u>Emergency Contact Information:</u>			
Emergency Contact:			
Name: _____		Home Phone: _____	
Relation to Patient: _____		Work Phone: _____	

I authorize my insurance company to pay benefits directly to my physician. I hereby consent to the release of medical information necessary to process any insurance claims and to any other doctor for the continuation of my medical care. I accept personal responsibility for any and all services in which I have been proven ineligible for medical benefits. I understand that a photocopy of this release is as valid as the original.

Patient Signature: _____ Date _____

(If patient is under 18 this must be signed by parent or guardian)