Patient # _____

NEW PATIENT INFORMATION FORM

Last Name: _____ First Name: _____

Middle Name: _____

Street: _____ City: _____ State: _____

Zip: _____ Home Phone: _____

Cell Phone: _____ Email: _____ Birth Date: __/__/__

Social Security Number: ___ - ___ - ___ Marital Status: M S D W _____

Primary Care Physician: _____ Phone: _____

Occupation: _____ Employer: _____

Street: _____ City/St. _____ Zip: _____

Work Phone: _____

RESPONSIBLE PARTY (if under the age of 18):

Name: _____ Relation: _____

Address (if different from above): _____ Phone: _____

How did you hear about our office?

Referred by Doctor: _____ Insurance Directory: _____

Friend: _____ Internet: _____

Phonebook: _____ Other: _____

PRIMARY INSURANCE _____

Subscriber (if other than self): _____ D.O.B.: _____

***Please provide your card to our receptionist so we can make a copy for our records.**

SECONDARY INSURANCE _____

Subscriber (if other than self): _____ D.O.B.: _____

***Please provide your card to our receptionist so we can make a copy for our records.**

EMERGENCY CONTACT: _____ Phone: _____

I authorize the release of medical information necessary to process any claim. I authorize payment of benefits either to myself or to DRS YALE AND KASSARIS as agreed upon at the time of treatment for services rendered. I further agree to be responsible for reasonable fees associated with the cost of collection on my account if not paid in full within 60 days of treatment. I give permission to be contacted via phone or mail.

SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY: _____ INPUT BY: _____

Associated Podiatrists

Fairfield	**North Haven**	**Greenwich**
1881 Post Road Fairfield, CT 06824	83 Washington Avenue North Haven, CT 06473	282 Railroad Avenue Greenwich, CT 06830