Albany Podiatry Associates, L.L.P.

531 7th Ave. • Albany, Georgia 31701

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Please Print

Patient's Name _____ (Last / First / MI) Date _____

Address _____ (Street / City / State / Zip Code)

Mailing Address _____

County _____ Sex _____ Place of Employment _____

Cell Phone Number _____ Address _____

Home Phone Number _____ Date of Birth _____ Age _____

Work Phone Number _____ Social Security Number _____

Marital Status _____ // African American // Native American // Caucasian // Hispanic // Other

Parent/Guardian if patient is a minor

Name _____
Address _____
Home Phone _____ Work _____
DOB _____ Sex _____
Social Security # _____
Place of Employment _____
Address _____
City _____ State _____ Zip _____

Spouse's Information

Name _____
Address _____
Home Phone _____ Work Phone _____
DOB _____ Sex _____
Social Security # _____
Place of Employment _____
Address _____
City _____ State _____ Zip _____

Insurance Information

Primary Insurance _____ Address _____
Subscriber's Name _____ Policy # _____ Group _____
Secondary Insurance _____ Address _____
Subscriber's Name _____ Policy # _____ Group _____
Will this be a Worker's compensation claim? _____

Medical History

Reason for Visit: _____
How long have you had this problem? _____
Name of your pharmacy? _____
What medication do you take? _____
Are you allergic to any drugs or medications? If yes, please list: _____
Referred by: _____ Family Physician _____

Authorization/Responsibility Agreement

I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to ALBANY PODIATRY ASSOCIATES. A copy of this can be considered as an original for insurance purposes. I authorize any holder of medical or other information about me to be released to my insurance carrier about my claim. I understand that I am responsible for all of the charges for all of the services rendered to me (or any member of family). I clearly understand that it is my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I agree to make arrangements for prompt payment of the bill.

Regulations pertaining to Medicare assignment of benefits apply.

PATIENT SIGNATURE _____ DATE _____
Parent/Guardian (if patient is a minor) Signature _____
Relationship to Patient _____
Street Address _____ City _____ St _____ Zip _____
Social Security # _____

No original records or x-rays will be released. Patient may request a copy of his/her records and x-rays. There may be a fee for this service.

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