

# Ruth Ann Cooper, DPM

[www.ruthanncooperdpm.com](http://www.ruthanncooperdpm.com)

## WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you.

### Personal Information

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Last Name First Name Initial

Address \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Marital Status:** ( ) single ( ) married ( ) widowed ( ) separated ( ) divorced **Gender:** ( ) Male ( ) Female

Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Family Physician/Pediatrician \_\_\_\_\_ Phone ( ) \_\_\_\_\_

### Insurance Care Holder Information (Name of family member who carries insurance)

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last Name First Name Initial

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Employer \_\_\_\_\_

### Primary Insurance

Primary Insurance Company Name \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

### Secondary Insurance

Secondary Insurance Company Name \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Soc. Sec # \_\_\_\_\_ D.O.B. \_\_\_\_\_ Employer \_\_\_\_\_

I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

PLEASE COMPLETE BOTH SIDES

