

Ruth Ann Cooper, DPM

www.ruthanncooperdpm.com

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form completely.
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 () divorce Gender: () Male () Female
Employer _____ Employer's Address _____
City _____ State _____ Zip _____ Work phone () _____
Family Physician/Pediatrician _____ Phone () _____

Insurance Card 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 Co. Name _____ ID # _____ Group # _____

Secondary Insurance

Secondary Insurance Co. Name _____ ID # _____ Group # _____

Subscriber's Name _____ Soc. Sec. # _____ Date of Birth _____
Relationship to patient _____ 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 _____

Emergency Contact Information

Name _____ Relationship to patient _____
 Last Name First Name Initial
Address _____ City _____ State _____ Zip _____
Home Phone () _____ Work phone () _____ Cell phone () _____

Patient Contact Information

Any physician, staff, employee or representative of Ruth Ann Cooper, D.P.M. has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons: (All patients must fill in the following on who we can release information to; talk to, by telephone, mail, etc.

_____	_____	_____	_____
Name	Relationship	Name	Relationship
_____	_____	_____	_____
Name	Relationship	Name	Relationship

() I do not want anyone to have access to my protected health information unless I provide explicit authorization.

Comments _____

Signature of Patient or Personal Representative

Date