Riverdale Podiatry & Foot Surgery

ONE STEP AHEAD

PATIENT INFORMATION

DATE: _____

NAME: _____

ADDRESS: _____

_____

_____

_

SOCIAL SECURITY #_____

DATE OF BIRTH: _____/_____/_____

TELEPHONE NO. ( ) _____

PRIMARY CARE PHYSICIAN (1st and last name):_____

TELEPHONE NO. (If Available): ( )_____**TOWN:**_____

NAME OF INSURANCE:_____

IF DIFFERENT FROM PATIENT: NAME OF INSURED _____

RELATIONSHIP TO INSURED:_____**POLICY HOLDER SS#**_____

FOR MEDICARE PATIENTS:

I request that payment of authorized Medicare benefits be made either to or on my behalf to Dr. Richard M. Steiner for services furnished to me by this provider. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

*****PATIENT'S SIGNATURE**_____

[FOR OFFICE USE ONLY: NPI NUMBER: _____**]**