PATIENT INFORMATION

PLEASE PROVIDE PHOTO ID AND INSURANCE CARD

DR. ELIZABETH PACOCHA
PHYSICIAN OF THE FOOT & ANKLE

Patient Name _____ Gender: ☐ Male ☐ Female
Last First Middle Initial

Date of Birth _____ **Age** _____ **Social Security No.** _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address _____ **City** _____ **State** _____ **Zip Code** _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Email Address _____

Employer Name _____ **Occupation** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Nearest Relative (not living with you) _____ **Telephone** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Insurance Company _____ **Group #** _____ **ID/Policy #** _____

Name of Policy Holder _____ **SSN** _____ **Date of Birth** _____ **Relationship to Patient** _____

Employer Name _____ **Occupation** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Secondary Insurance _____ **Group #** _____ **ID/Policy #** _____

Name of Policy Holder _____ **SSN** _____ **Date of Birth** _____ **Relationship to Patient** _____

Insurance Authorization and Assignment

Co-payments are due at the time of service. We will bill all contractual insurance companies, however you are ultimately responsible for all charges, whether or not paid by your insurance. To avoid late payment fees or finance charges, all unpaid balances must be paid within 60 days.

I authorize Dr. Elizabeth Pacocha and her staff to disclose my health information to the insurance carrier(s). Dr. Pacocha will use and disclose my health information in order to obtain payment for services rendered and allow insurance companies to process claims. I understand that this authorization is voluntary.

Patient or Guardian Signature _____ **Date** _____