



24022 Calle De La Plata, Suite 410
Laguna Hills, CA 92653
Telephone: (949) 581-2520
FAX: (949) 581-7467

NEW PATIENT INFORMATION:

Date: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____ City/State/Zip: _____

Home Phone () _____ Cell Phone () _____ Work () _____

SS#: _____ Date of Birth: _____ Age: _____ Sex: M / F DL#: _____

Employer Name: _____ Address: _____

City/State/Zip: _____ Occupation: _____

Marital Status: S/M/D/W Employment: FT/PT/SELF/RET Student: FT/PT/NONE

How did you hear about our office? _____

Spouse Name: _____ Spouse Employer: _____

Address: _____ City/State/Zip: _____ Tel#: _____

Insurance Name #1: _____ Address: _____

City/State/Zip: _____ ID# _____ GRP#: _____

Policy Holder: _____ Date of Birth: _____

Employer Name: _____

Insurance Name #2: _____ Address: _____

City/State/Zip: _____ ID# _____ GRP#: _____

Policy Holder: _____ Date of Birth: _____

Employer Name: _____

In Case of Emergency Notify: _____

Address: _____ City/State/Zip: _____

Phone#: () _____ Relationship to Patient: _____

Authorizations and Responsibilities: I hereby authorize Dr. Greenberg to render podiatric care. I hereby authorize my insurance benefits to be paid directly to the physician. I hereby authorize the release of information required in processing claims. I am financially responsible for non-covered services or any amounts not paid by the insurance company within 60 days. All Medicare patients will be charged the prevailing charge allowed by Medicare.

Signature

Date