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PLEASE PRINT

TODAY'S DATE _____

DIABETIC? YES _____ NO _____

PREFERRED LANGUAGE _____

ALLERGIES? YES _____ NO _____

♂ MALE
♀ FEMALE ()

LAST NAME / APELLIDO FIRST NAME / NOMBRE M.I. GENDER/GENERO HOME PHONE/TELEFONO DE CASA

D.O.B / FECHA DE NACIMIENTO SOCIAL SECURITY #/ NUMERO DE SEGURO SOCIAL CELL PHONE/TELEFONO CELULAR

ADDRESS/DIRECCION APT# CITY/CIUDAD STATE/ESTADO ZIP CODE

EMERGENCY PHONE (NOT YOUR HOME #) CONTACT'S NAME EMAIL ADDRESS/ CORREO ELECTRONICO

PARENT/GUARDIAN'S FULL NAME-NOMBRE DE MADRE O PADRE

REQUIRED BY GOVERNMENT: RACE: AMERICAN INDIAN/ALASKA NATIVE NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER NON HISPANIC OR LATINO
ASIAN BLACK OR AFRICAN AMERICAN WHITE ETHNICITY: HISPANIC OR LATINO

PRIMARY PHYSICIAN / DOCTOR PRIMARIO PHYSICIAN'S PHONE/TELEFONO DEL DOCTOR LAST VISIT/ULTIMA VISITA

PHARMACY NAME & PHONE# - FARMACIA & TELEFONO PRESCRIPTION PLAN YES NO

EMPLOYMENT INFORMATION / INFORMACION DE TRABAJO

COMPANY NAME CITY/STATE WORK PHONE NUMBER

PRIMARY INSURANCE INFORMATION / INFOMACION DE SEGURO PRIMARIO

INSURANCE NAME ID# NO INSURANCE.

SUBSCRIBER'S NAME DATE OF BIRTH RELATIONSHIP TO THE PATIENT

SECONDARY INSURANCE? _____

FOOT PROBLEM BRINGING YOU TO OUR OFFICE

PROBLEMA EN EL PIE QUE LO TRAE A LA OFICINA

PLEASE CHECK: RIGHT/ DERECHO LEFT/ IZQUIERDC BOTH

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE PAYMENTS, HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE DR. _____ TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR FOR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

*PATIENTS WHO HAVE MEDICARE SHOULD BE AWARE THAT CERTAIN SERVICES ARE NOT COVERED BY MEDICARE AND THE PATIENT IS RESPONSIBLE FOR THEIR PAYMENT.**

TODAY'S DATE PATIENT'S SIGNATURE --- PARENT'S SIGNATURE (ALSO PRINT NAME)