PATIENT INFORMATION

Name:	DOB:	Age:	Gender: M F
Address:	City:	State:	Zip:
Preferred e-mail:			
Primary Phone Number: H C W	Secondary Phone Number: H C W		
Emergency Contact:	Relationship:	Phone #:	
Personal Status: Single Married Divorced Widowed	SSN:		
Occupation:	Student Status: Full-time Part-time N/A		
Employment Status: Full-time Part-time Retired			
Place of Employment:	Address:		
Referred by:			

POLICYHOLDER INFORMATION (Please fill in if patient is not the policyholder)

Name:	DOB:	Gender: M F
Address (if different):		
Place of Employment:	Address:	
SSN:	Relationship to Patient:	

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	SECONDARY INSURANCE COMPANY
Insurance Company:	Insurance Company:
Member ID:	Member ID:
Group No:	Group No:
Copay Amount:	Copay Amount:
Do you need a referral from your PCP?	Do you need a referral from your PCP?

ASSIGNMENT OF BENEFITS:

*I authorize payment of benefits to Bolingbrook Foot Specialists, and/or Dr. Jeffery M. Mackler, for professional services rendered.

*I also authorize the release of any medical information necessary to process medical claims.

*It is my responsibility to notify Bolingbrook Foot Specialists of any changes in the above information.

*I have completed the above information and certify that this infomation is true and correct to the best of my knowledge.

*I understand that while this office **does accept Medicare**, it **does not accept Medicaid** in any form, not as a primary insurance, not as a secondary insurance. This office also does not accept any Medicare-Medicaid Alignment Initiative (MMAI).

Signature: **Date:**

FINANCIAL POLICY:

*I understand and agree, that regardless of my insurance status, that I am ultimately responsible for the balance on my account for any professional services rendered or products purchased.

*If I do not pay my balance in a timely manner, I understand that additional fees may be incurred.

Signature: **Date:**