

PATIENT INFORMATION

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NAME _____ DATE OF BIRTH ____/____/____

RESPONSIBLE PARTY _____ SS# _____

HOME ADDRESS _____

CITY _____ ZIP CODE _____ SEX M F

HOME TELEPHONE _____ MARITAL STATUS _____

E-MAIL ADDRESS _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ WORK PHONE _____

CITY _____ ZIP CODE _____

INSURANCE CO _____

POLICY # _____ GROUP # _____

DRIVERS LICENSE # _____ PREVIOUS PODIATRIST _____

REFERRED BY _____ FAMILY M.D. _____

WHAT IS YOUR FOOT PROBLEM _____

PLEASE NOTE:

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION OR OTHER INFORMATION NEEDED FOR THE PROCESSING OF THE ATTACHED MEDICAL CLAIM AND REQUEST THAT PAYMENT BE MADE DIRECTLY TO THE TREATING DOCTOR. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. IT IS UNDERSTOOD THAT THE PATIENT IS RESPONSIBLE FOR THE MEDICAL SERVICES THEY RECEIVE.

DATE _____

SIGNATURE _____
(PARENT SIGNATURE IF PATIENT IS A MINOR)