Dr. Angeles Valdes, DPM and Dr. Ann Marie Kulekowskis, DPM
Podiatry and Foot Surgery

WELCOME TO OUR OFFICE

PERSONAL INFORMATION

NAME______________________________________TODAY'S DATE_______________

SOCIAL SECURITY #_____________DATE OF BIRTH________AGE___SEX M___F___

SINGLE___MARRIED___DIVORCED___WIDOWED___SEPARATED___PARTNERSHIP___

HOME ADDRESS____

CITY______________________________STATE________ZIP CODE_______________

HOME TELEPHONE (___) _____________CELL PHONE (___) ________________________

PRIMARY PHYSICIAN NAME_________________________PHONE # (___)____________

ADDRESS______________________________________LAST VISIT DATE ____________

EMPLOYED BY_________________________________OCCUPATION_______________

ADDRESS ____PHONE #_____________

SIGNIFICANT OTHER NAME____

PHONE NUMBER TO CONTACT____

SOCIAL SECURITY #________________________DATE OF BIRTH_________________

EMPLOYED BY_________________________________OCCUPATION_______________

ADDRESS ____PHONE #_____________

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY, CONTACT:
NAME_________________________________RELATIONSHIP_______________________

HOME PHONE #_______________________CELL PHONE #__________________________

WORK PHONE #_______________________

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE:______________________?

INSURANCE INFORMATION

WHO IS RESPONSIBLE FOR THIS ACCOUNT______________________________

RELATIONSHIP TO PATIENT______________________________

INSURANCE COMPANY______________________________

ADDRESS______________________________PHONE #____________

ID #______________________________GROUP #______________________________

IS THERE A CO-PAY FOR THIS INSURANCE? YES___NO___ AMOUNT________

IS THERE A DEDUCTIBLE FOR THIS ACOUNT? YES___NO___AMOUNT________

IS PATIENT COVERED BY A SECONDARY INSURANCE? YES______NO______

SECONDARY INSURANCE NAME ______________________________

ADDRESS______________________________PHONE #____________

ID #______________________________GROUP #______________________________

IS THERE A CO-PAY FOR THIS INSURANCE? YES___NO___ AMOUNT________

IS THERE A DEDUCTIBLE FOR THIS ACOUNT? YES___NO___AMOUNT________

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with______________________________
(Name of insurance company)
and assign directly to Dr. Valdes and/or Kulekowskis Podiatry Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I authorize the use of my signature on all insurance submissions.

The above named physicians may use my healthcare information and may disclose such information to the above named insurance companies, and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, medigap benefits, be made either to me or on my behalf Dr. Valdes and Kulekowskis Podiatry Center for any services rendered to me by these providers. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the centers for Medicare and Medicaid services and medigap insurer, and their agents any information needed to determine these benefits for related services.

Signature of Beneficiary/Guardian/Personal Representative______________________________

Printed name of Beneficiary/Guardian/Personal Representative______________________________

Date:______________________Relationship to beneficiary______________________________