Steven L. Ginex, DPM Inc.

Palm Desert Podiatry Center

Would you kindly complete this new patient information for the office. It is very important that you be as thorough as possible so that we may expedite your insurance billing and obtain reimbursement on your behalf.

Referral by ○ **Dr.** _____ ○ **Friend** _____ ○ **Yellow Pages**
○ **Website** ○ **Insurance Company** ○ **Sign/Location** ○ **Other**

Patient's Name:_____ **Sex** ○ **M** ○ **F**

Date of Birth: _____ **Age:** _____ **Soc. Sec. #:** _____

Marital Status: ○ **Single** ○ **Married** ○ **Divorced** ○ **Widowed** **Spouse Name** _____
or Responsible Party

Home address: _____
Street **City** **State** **Zip**

Home Phone: _____ **Cell #:** _____ **E-mail Address:** _____

Student: ○ **Full-time** ○ **Part-time** **Employment:** ○ **Full-time** ○ **Part-time** ○ **Retired**

Employed by:_____ **Business address:**_____

Please note: The following information on race, ethnicity and language, is required by the federal government.

Race: O **Caucasian** O **American Indian or Alaskan Native** O **Hispanic** O **African American**
O **Pacific Islander** O **Other** O **Decline to state**

Ethnicity: O **Hispanic** O **Non-Hispanic** O **Decline to state**

Prefer Language: O **English** O **Spanish** O **French** O **Other** _____

********** BILLING INFORMATION **********

Primary Carrier: _____ **Secondary:** _____

Insured's Name: _____ **Insured's Name:** _____

Insured's Date of Birth _____ **Insured's Date of Birth** _____

Relation to patient: O **Self** O **Spouse** O **Parent** O **Other** **Relation to patient:** O **Self** O **Spouse** O **Parent** O **Other**

ID#: _____ **GRP #:** _____ **ID#:** _____ **GRP #:** _____

Effective Date: _____ **Effective Date:** _____

********** **AUTHORIZATION** **********

I hereby give my permission to Dr. Ginex to administer minor treatments as may be deemed necessary in the treatment and diagnosis of my foot and/or ankle complaints.
I hereby assign all medical and surgical benefits, including major medical to which I am entitled, including Medicare, Private and health plans to Steven L. Ginex, DPM.
***Remember**: We bill your insurance as a courtesy but if we have not received payment within 60 days, you will receive a statement requesting payment in full.*
I fully understand that I am responsible for any amount applied to the deductible, co-pay, no payable charges and any denied claim.

SIGNATURE OF PATIENT: _____ **Date:** _____

SIGNATURE OF INSURED: _____ **Date:** _____