Dr. Lawrence A. Czelusta

9325 Schoenthal Road North, Suite 1, San Antonio, Texas 78266

WELCOME TO OUR OFFICE

DATE: _____ **PATIENT INFORMATION**

ALL THE INFORMATION REQUESTED ON THIS PAGE IS NEEDED SO THAT WE CAN PROVIDE YOU WITH THE BEST POSSIBLE CARE. PLEASE COMPLETE EACH PART OF THIS FORM SO THAT WE HAVE COMPLETE INFORMATION ON YOU. THANK YOU.

PATIENT NAME: _____
(as it appears on your insurance card)
NICKNAME: _____
ADDRESS: _____
City State Zip
BILLING ADDRESS (IF DIFFERENT): _____
DATE OF BIRTH: _____ SEX: M _____ F _____
SOCIAL SECURITY NUMBER: _____
MARITAL STATUS: S _____ M _____ W _____ D _____
HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____
EMPLOYER NAME: _____
INSURED'S NAME: _____ INSURED'S DATE OF BIRTH: _____
WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____

INFORMATION ON SPOUSE OR PARENT IF PATIENT IS A MINOR:
NAME: _____
EMPLOYER NAME: _____ WORK PHONE: _____

NEXT OF KIN:
NAME: _____
ADDRESS: _____
City State Zip
PHONE: _____ RELATIONSHIP: _____

IN CASE OF EMERGENCY, NOTIFY:
NAME: _____
ADDRESS: _____
City State Zip
PHONE: _____ RELATIONSHIP: _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____
PHYSICIAN: _____ DATE LAST SEEN _____

IF YOU HAVE MEDICAL COVERAGE, PLEASE FURNISH US WITH YOUR CARD/CARDS AND DRIVER'S LICENSE TO COPY FOR YOUR FILES.
IF YOUR INSURANCE REQUIRES A CO-PAY, PLEASE PAY AT THE TIME OF SERVICE.

IT IS OUR PLEASURE TO PROVIDE YOU WITH YOUR MEDICAL NEEDS. OUR POLICY IS TO RECEIVE PAYMENT AT THE TIME OF SERVICE, UNLESS YOU ARE A MEDICARE PATIENT. PLEASE INDICATE BELOW YOUR METHOD OF PAYMENT.

CASH _____ CHECK _____ VISA _____ MASTERCARD _____

Please list any allergies you have (medication, food, etc.): _____
_____

Please list any medication you are now taking: _____
_____

If you have or have had any of the following, please check:

____ Cramps or numbness in feet or legs
____ High Blood Pressure
____ Swelling in ankles or feet
____ Heart Disease
____ Diabetes
____ Asthma
____ Difficulty in healing
____ Other

____ Ulcers
____ Arthritis
____ Varicose Veins
____ Anemia
____ Gout
____ Blood Disease
____ Surgery

Please list any hospitalizations or surgery in the last five years: _____
_____

Are you interested in hearing about optimal vitamin supplementation? _____

Your Foot Problem: _____

MEDICAL CONSENT AND FINANCIAL RESPONSIBILITY

I (we) hereby give my (our) consent to Lawrence A. Czelusta, D.P.M. and Staff for treatment regarding my condition:

_____ **DATE:** _____
PATIENT SIGNATURE (OR AUTHORIZED PERSON)

MEDICARE: If applicable, I certify that the information given by me in applying for payment under Title XVIII for the Social Security Act is correct. I request payment of authorized Medicare benefits be made on my behalf to Dr. Lawrence A. Czelusta.

_____ **DATE:** _____
SIGNATURE OF MEDICARE PATIENT

RECORDS RELEASE: I hereby authorize the release of any information, including medical and billing information, to my referring doctor, insurance company, the responsible party named above, and the immediate family.

Date: _____ Signed: _____