Michael A. Ruiz, DPM
3910 Caughey Rd, Ste 130
Erie, PA 16506
(814) 833-3668

PATIENT INFORMATION

Welcome to our office…. Please **fill out** *this form* **completely** *and* **sign it**. *Thank You.*

Patient Name________________________________

Date of Birth____________________Gender:__M__F Hispanic?_Yes__No

Race__Caucasian__African American_Native American_Pacific Islander__Asian_Other

Preferred Language___________________ Marital status:__Married__Single__Other

Address(**street**)____

City, State&Zip____

Home Phone #______________________________Work Phone #________________________

Cell phone #___________________________**E-mail(for reminders only)**__________________

Employer________________________________**Family Physician**____________________

How did you hear about the practice? (circle one)

Internet/Google_________ Friend/Family_________ Doctor Referral (who?)___________________

Insurance Company_________ Facebook_________ Other___________________________________

Emergency Contact (Name & phone number) ____

PRIMARY MEDICAL INSURANCE

Insurance Name______________________________ Subscriber Name_______________________

ID #___________________________Group # ____

Relationship to Policy Holder: Self__Spouse__Other__ Date of Birth________________

Do You Have a Co-pay? Yes__Amt $ ________ __ No .

Does your insurance require a referral? Yes __ No___

SECONDARY MEDICAL INSURANCE

Carrier Name__________________________ Subscriber Name_____________________________

Policy #______________________________ Group #______________________________

ASSIGNMENT OF BENEFITS

I hereby authorize the release of any information relating to all claims submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or my dependents, and I will be bound by this signature as though the undersigned had personally signed the particular claim(s). I hereby authorize the insurance company(ies) listed to pay and hereby assign directly to Lake Erie Podiatry all benefits, if any, otherwise were payable to me for services. I understand that I am financially responsible for all charges incurred. I further acknowledge that my insurance benefits, when received by and paid to Lake Erie Podiatry will be credited to my account in accordance with the above said assignment.

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Patient's Signature Today's Date