Dr. Alan R. Warren, D.P.M
Foot & Ankle Specialist

PHYSICIAN AND SURGEON OF THE FOOT
BOARD CERTIFIED
24836 HARPER AVENUE
SAINT CLAIR SHORES, MI. 48080
PHONE: 586-778-0400 FAX: 586-778-5263

*TODAY'S DATE:*_____

PATIENT INFORMATION

Please complete the form below. The information requested is a necessary part of your chart and will assist our staff in servicing you more efficiently.

MR, MISS, MRS _____BIRTHDATE_____/_____/_____ SEX M F

ADDRESS_____CITY_____STATE_____ ZIP _____

HOME PHONE (____)_____ CELL PHONE (_____)_____

SOCIAL SECURITY NUMBER _____-_____-_____

FAMILY DOCTOR_____PHONE NUMBER (____)_____

EMPLOYER _____OCCUPATION_____

EMPLOYER ADDRESS_____WORK PHONE (_____)_____

Spouse or person to contact in case of emergency:

NAME_____RELATIONSHIP_____

ADDRESS_____CITY_____ STATE_____ ZIP_____

HOME PHONE (_____)_____CELL/WORK PHONE (_____)_____

REFERRED BY: _____RELATIONSHIP_____

NAME OF YOUR INSURANCE COMPANY _____

ONE TIME INSURANCE AUTHORIZATION

I, _____REQUEST PAYMENT OF AUTHORIZED MEDICARE/OR OTHER INSURANCE BENEFITS BE MADE ON MY BEHALF TO **DR. A.R. WARREN**, FOR ANY SERVICES FURNISHED BY HIM. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS OR INDEPENDENT INSURANCE AGENTS, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES. I ASLO UNDERSTAND THAT ANY CO-PAYMENTS OR DEDUCTABLES FOR SERVICES RENDERED WILL BECOME MY RESPONSIBILITY. $3.00 SERVICE FEE WILL BE ADDED TO ALL PATIENT ACCOUNTS OVER 30 DAYS OLD.

_____

SIGNATURE