North Bridge Podiatry Group, P.C.

Patient: _____

Address: _____

_____

_____

Sex: _____ Age: _____ DOB: _____

Email: _____

Occupation: _____

Employed by: _____

Home phone: _____

Business phone: _____

Other phone: _____

Marital status: _____

Spouse/kin: _____

Phone: _____

Occupation: _____

Employed by: _____

Referring M.D.: _____

Address: _____
(street) (city) (state) (zip)

INSURANCE INFORMATION

MEDICAL INSURANCE	SUBSCRIBER / DOB	RELATIONSHIP	CERTIFICATE #
BC/BS Plan	/		
Medicare			
Medex			
Welfare (Medicaid)			
Other:	/		
	Suffix:	Group #:	

Address: _____
(street) (city) (state) (zip)

RESPONSIBLE PARTY for MINOR CHILD

Parent's Name: _____
Address: _____
_____
_____
Phone: _____

WORKMAN'S COMPENSATION

Party to be billed: _____
Address: _____
_____
_____
Claim/File #: _____ Date of Accident: _____

AUTHORIZATION

I hereby authorize North Bridge Podiatry Group to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to North Bridge Podiatry Group all payments for medical services rendered to myself or my dependents. I am aware that it is my obligation to know my insurance company's policies and that I am responsible for payment if I have not fulfilled their requirements.

Signature: _____ Date: _____

CONSENT FOR TREATMENT

I hereby request and voluntarily consent to such office care, including routine diagnostic procedures and medical treatment as may be deemed necessary by North Bridge Podiatry Group and/or its designees.

Signature: _____ Date: _____