

WELCOME TO OUR OFFICE

Ronald A. Nagy DPM
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Mesa, Arizona 85203
480-833-4728

TODAY'S DATE

Thank you for choosing our office.

In order to serve you properly we will need the following information. All information will be strictly confidential.

Ethnicity: White American Indian/Alaskan Native Asian Native Hawaiian/Pacific Islander
 Hispanic/Latino Black/African American Declined

Patient's name _____ Birthdate ____/____/____ Marital Status
S M D W

Arizona Address _____ City _____ State _____ Zip _____ Phone _____

Out of state address _____ City _____ State _____ Zip _____ Cell phone _____

Email _____ Occupation/Employer _____ Address _____ Work phone _____

Do you have medical Insurance? Yes No If no, how do you intend to pay? Cash Check C-Card

Insurance: _____ Relationship to Policyholder: _____ Name of Policyholder: _____

SSN: _____ Policyholder birthdate: ____/____/____ Policyholder SSN: _____

Is this through the Policyholder's employer? Yes No Policyholder's employer: _____

Is there a secondary Ins? Yes No Secondary insurance: _____

If different from above

Relationship to Policyholder: _____ Name of Secondary Policyholder: _____

Secondary SSN: _____ Secondary birthdate: ____/____/____ Secondary's Employer: _____

Name of Emergency Contact _____ Relationship to patient _____ Phone _____

Nearest friend or relative not residing with you _____ Relationship to patient _____ Phone _____

Who may we thank for referring you? / How did you hear about us? _____

What is your chief complaint? _____

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage.

Patient, Parent, or Guardian Signature _____

Date _____