PERSONAL FOOT CARE LLC

2020 Wakefield St., Petersburg, VA 23805 * 804/732-1211 * 804/733-5946 (fax)
424 Bracey Lane, South Hill, VA 23970 * 434/447-6988 * 434/447-5058

Name______________________________________Birth Date__________ Age_____ M____ F____
Address___________________________________City___________________State_____Zip_____
Home Phone______________ Cell ______________Other__________ SS#__________________
[ ] Married [ ] Single [ ] Divorced [ ] Widow

Employer__________________________Occupation______________Phone______________
Address___________________________________City___________________State_____Zip_____
[ ] Full Time [ ] Part Time [ ] Unemployed

Parent/Gardian/Spouse__________________________SS#_______________ DOB__________
Address___________________________________City___________________State_____Zip_____

Family Physician____Phone______________
In Case of Emergency Contact_______________________________Phone______________
Employer____

Medical Insurance Info Primary: [ ] Anthem BC/BS [ ] Medicare [ ] Medicaid [ ] Other__________
Name of Ins. Co.____
Ins. ID#______________ Group #______________ Primary Holder [ ]Self [ ] Spouse __________
Spouse Birth Date______________ Spouse Employer_________________________SS#__________

Have you visited a Podiatrist (foot specialist) before? [ ] Yes [ ] No Shoe size:__________
Podiatrist's Name______________________________ Date of Last Visit________________

How did you hear about us? [ ] Referral [ ] Yellow Pages [ ] Newspaper [ ] Radio [ ] Other______

List Current Medications____
____

Do you have any allergies to MEDICATIONS or FOODS? [ ] No [ ] Yes
List them____

Have you been treated for diabetes (sugar)? [ ] No [ ] Yes
If yes, diabetes controlled by [ ] Diet [ ] Pill [ ] Insulin Dosage________

Describe your chief complaint (foot problem) ______________________________________
____
____

AUTHORITY TO TREAT STATEMENT: I ____
(if minor)______________________hereby give permission to Samuel W. Person, DPM and Associates of Personal Foot Care LLC to administer treatment and to perform such examinations as may be deemed necessary or advisable in the diagnosis and treatment of my condition.

Signature______________________________Date____________

BENEFICIARY (insured person) LIFETIME SIGNATURE AUTHORIZATION

Name of Beneficiary______________________________________Ins ID #________________
"I request that payment of authorized MEDICARE and/or ______________________________ benefits to be made either to me or on my behalf to Personal Foot Care LLC for any services furnished by their physicians. I authorize any holder of medical information about me to re release to the Health Care Financing Administration and it agents any information needed to determine these benefits or benefits payable for related services." I WILL BE RESPONSIBLE FOR PAYMENT OF SERVICES THAT MY INSURANCE DOES NOT PAY.

Signature______________________________Date____________
Witness________________________________Date____________

Revised 5/16/08