DR. ERIC T. TRAVIS   DR. WESLEY M. KOBAYASHI

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PLEASE PRINT LEGIBLY AND CLEARLY - ALL INFORMATION MUST BE COMPLETED

Last Name:________________________ First Name:______________________________ MI:______

M / F   CDL#:______________________ SSN:____________________________ DOB:____________

Street Address:__________________________ City:____________________ State:____ Zip:_______

Home Phone:_______________ Cell Phone:_________________ Work Phone:__________________

Are you a student: Y / N Part Time: _________ Full Time: _________ School:___________________

Who may we thank for referring you to our office?:____

EMERGENCY CONTACT INFORMATION

Name: ___________________________ Relationship:___________________Phone:___________

EMPLOYER INFORMATION

Employer Name:______________________Phone:___________________Occupation:_____________

INSURANCE RESPONSIBLE PARTY IF NOT PATIENT

Name:__________________________ Phone:___________________SSN:____________DOB:______

Street Address:__________________________ City:____________________ State:____ Zip:______

Relationship to Patient:____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize Eric Travis, DPM, Wesley Kobayashi, DPM, or Daniel Recalde, DPM, to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to the doctor. I certify that the information I have reported with regard to my insurance company is correct. ***I will notify the office of any changes to my personal information and insurance.*** If I am not covered by insurance at any time, I understand that I am financially responsible for services rendered. I understand that I am responsible for any amount not covered by insurance such as services not covered, deductible, coinsurance, and co-pays. ***Co-pays are due at the time of service***. This authorization may be revoked by either me or my insurance company at the time of writing.

_____________________________________   ______________________________

Signature   **Date**