COMPREHENSIVE PODIATRY CENTER, BROOKLYN HEIGHTS, NY

GREG E. COHEN, D.P.M., F.A.C.F.A.S.
JASON E. FEINBERG, D.P.M.
BRIAN DAWSON, D.P.M.

Welcome to our practice!

DATE: _____

NAME: _____ ADDRESS: _____
Last First Middle

APT: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: HOME: _____ WORK: _____ CELL: _____

SEX (M/F): _____ AGE: _____ BIRTHDATE: _____ SOCIAL SECURITY #: _____

PARENT/GUARDIAN (if under 18): _____
Name Address Phone

MARITAL STATUS: [ ]Single [ ]Married [ ]Divorced OCCUPATION: _____ EMAIL: _____

EMPLOYER: _____
Name Address Phone

EMERGENCY CONTACT: _____
Name Phone Relationship

WHOM MAY WE THANK FOR REFERRING YOU? _____

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

POLICY NUMBER: _____ PHARMACY NAME & TEL. NUMBER: _____

If insured is same as patient, skip this section:
NAME OF INSURED: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ DOB: _____

PHONE: _____ SEX (M/F): _____ SOCIAL SECURITY #: _____

PRIMARY CARE PHYSICIAN: _____
Name Address Phone

PLEASE STATE THE REASON FOR TODAY'S VISIT: _____

_____

ASSIGNMENT & RELEASE

I hereby authorize my insurance company to make payments directly to Greg E. Cohen, DPM, Jason E. Feinberg, DPM or Brian Dawson, DPM for all professional health care related products and services. I understand that I am fully responsible for all charges including any amount my insurance company or Medicare does not cover, including in-network coinsurance and deductibles. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all submissions.

I certify that the above information is true and correct to the best of my knowledge. I hereby give my permission to Dr. Cohen and/or Dr. Feinberg and/or Dr. Dawson to administer and perform such examinations and procedures as may be deemed necessary in the diagnosis and treatment of my foot and ankle conditions.

PATIENT'S SIGNATURE: _____ DATE: _____