

**CARY L. COPELAND, DPM, INC.
MEDICAL AND SURGICAL TREATMENT OF THE FOOT**

Dr. Cary L. Copeland

Dr. Renee L. Ash

Dr. Dominic A. Rizzo

PATIENT INFORMATION PRINT FIRMLY & CLEARLY

(Circle One) Dr. Mr. Miss Mrs.		Patient's First Name	Middle Name	Last Name	Home Phone ()	Spouse's Name
Patient's Home Address					Number/Street/City/State/Zip Code	
Patient's Employer					Patient's Occupation	Business Phone
Employer's Address						
Age	Sex	Birth Date		Social Security No.		

PRIMARY INSURANCE INFORMATION

Full Name of Responsible Person (Policy Holder)		Birth Date	Relationship To Patient	Driver's License No.
Responsible Party's Address (if different from Patient's)		Number/Street/City/State/Zip	Responsible Party's Social Security Number	Home Phone ()
Responsible Party's Employer & Employer's Address		Number/Street/City/State/Zip	POLICY # OR ID#	Business Phone ()

SECONDARY INSURANCE INFORMATION

Full Name of Responsible Person		Birth Date	Relationship To Patient	Driver's License No.
Responsible Party's Address (if different from Patient's)		Number/Street/City/State/Zip	Responsible Party's Social Security Number	Home Phone ()
Responsible Party's Employer's Address		Number/Street/City/State/Zip	POLICY # OR ID#	Business Phone ()

MEDICAID PATIENTS

Case Name (As it appears on your card)	Enter 10 Digit Case Number	Enter Patient's 2 digit number
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WORKERS' COMPENSATION

Employer's Name & Address	Date of Injury	Claim Number
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MEDICAL INFORMATION

Who is your primary care physician (family physician)? _____

Please describe the reason for you visit today? _____

How did you hear of this office? Yellow Pages Internet or Web Physician -- Name _____

Existing Patient or Friend -- Name _____ Other -- _____

Please describe any previous treatment for this problem: _____

In Case of Emergency (Other than spouse or parent)		
Name	Address	Phone Number ()

I give permission to Cary Copeland D.P.M., Inc and his assistants to administer treatment for my foot and ankle conditions. I understand that I am financially responsible for all services rendered whether covered by insurance or not. I am also responsible for all fees incurred if no referral is received for my care.

I authorize the release of any medical or other information necessary to process my insurance claims. I authorize payment of medical benefits directly to Cary Copeland D.P.M., Inc and that I am responsible for any unpaid balance on my account.

Signature _____ Date _____