Foot HealthCare of Delaware

Patient Information

Name _____ Date of Birth _____

Address _____

City _____State _____Zip Code _____

Telephone _____Cell Phone _____

Email address _____ SS Number _____

Emergency Contact _____Phone _____

Primary Care Physician _____Phone _____

Insurance Information

Primary _____ ID # _____

Address _____ Group _____

_____ Telephone _____

Secondary _____ ID # _____

Address _____ Group _____

_____ Telephone _____

Authorization

I authorize Dr. Gina M. Freeman to provide podiatric medical services to the above named patient. I authorize my insurance company to pay to the doctor all benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the doctor to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____Date_____

2323 Pennsylvania Avenue Suite 2B Wilmington, DE 19806 302-765-2505