Welcome to

1477 Louisiana Ave, STE 101
New Orleans, LA 70115
Phone: 504-302-1586 Fax: 504-373-6813
www.nolasolepodiatry.com

Patient Information

Date: ___________________________________

Name: __________________________________

Date of Birth: ______________Age__________

Gender: ☐ Male ☐ Female

Address: ________________________________

____

Home #:_____________Cell #:______________

Work #:___________________

Marital Status: ☐ Single ☐ Married

Patient SS#:_____________________________

Occupation: _____________________________

How did you hear about our practice?

☐ Referral from Dr.___________________

☐ Friend ☐ Newspaper

☐ Radio ☐ Sign

☐ Website ☐ Other____________

In Case Of Emergency, Contact:

Name: __________________________________

Relationship: ____________________________

Contact #:_______________________________

Secondary #:_____________________________

May we leave a personal medical information on your answering machine? YES NO

Insurance Information

Primary Insurance Co: ____________________

ID #:_________________ Group #: __________

Account Holder: ___________________________

Address (if different from patient) ___________

____

Relationship to Patient: ____________________

Date of Birth: ____________ SS#: __________

Is patient covered by additional insurance? Yes ☐ No ☐

Secondary Insurance Co: __________________

ID #:_______________ Group #: ___________

Account Holder: ___________________________

Address (if different from patient) ___________

____

Relationship to Patient: ____________________

Date of Birth: ___________ SS#: ___________

INSURANCE/ MEDICARE AUTHORIZATION AND ASSIGNMENT RELEASE

I, the undersigned, certify that I or my dependent have insurance coverage with________________________ and assign directly to Robertson Foot and Ankle all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions. MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Robertson Foot & Ankle for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents and information needed to determine these benefits for the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

X__________________________ Date________________
Responsible Party Signature