# JAMES J. DeLORENZO, D.P.M

Physician of Podiatric Medicine and Surgery

## Patient Information Form

**Name**:________________________________________________________________
(last) (first) (middle)

**Today's date**:__________________ **Gender:** Male / Female **Birth Date**:_____/_______/________

Address:________________________________________________________________
(street)

________________________________________________________________
(city) (state) (zip)

**Social Security #:**___________________________________________

**May we leave a message?**

**Home telephone #** ( )_______-_______________ Yes / No

**Alternative Phone #** ( )______-_____________ Yes / No

**Your e-mail address:** ___________________________________@__________________________________

**Primary Language**: ___________________________

**Marital Status**: Single Married Divorced Widow/ Widower Life Time Partner Partner's Name:______________________

**Primary Care Physician:** _____________________________________**date of last visit:** _______________________

**Do you have a legal guardian or healthcare power of attorney?** Yes No
If yes, Name: _____________________________ Relationship: _____________ Phone #: _____________________

**Emergency Contact**: ___________________________ Relationship: _____________ Phone #: _________________

**Pharmacy**: ______________________________ Location: ___________________ Phone #: __________________

Is there a family member or other person you would like for us to share your medical information?
No / Yes, Name(s)_______________________________________________________________

**Insurance Information**

**Primary Insurance Company Name:**_________________________________________________________________

Insured Name: ______________________________________________ Date of Birth ______________ __________

Identification# ______________________________________________ Group # ____________________ ________

**Secondary Insurance Company Name:** ________________________________________________________________

Insured Name: ______________________________________________ Date of Birth ______________ __________

Identification# ______________________________________________ Group # ____________________ ________

**Please see reverse side →**

If other then patient, who is responsible for payment? ________________________ Relationship? ________________

Address:_____________________________________________________________________________________

(street) (city) (state) (zip)

Phone #: ______________________________

***How did you hear about us?*** Family Friend Yellow Pages Insurance Company Physician Advertisement Other

***Someone we can thank for referring you to our office***:____________________________________________________

**AUTHORIZATION**

I hereby authorize the Practice, or its representatives to disclose, upon requested, any and all information with respect to the above named patient, for any illness or injury, medical history consultation, prescriptions, or treatment and copies of all medical records. I hereby "assign" or authorize the Practice to file insurance claims on my behalf. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. A Photostatic copy of this authorization shall be considered as effective and valid as the original.

**AGREEMENT TO PAY**

In the event that my medical insurance does not pay for services rendered to me by James J. DeLorenzo, DPM, PLLC, or if a valid referral is not generated by my Primary Care Physician for services rendered, I agree to pay the usual and customary fees for these services.

**Patient/ Guardian Signature:**__________________________________________________**date:**__________________

**Relationship:**________________________________________________________________