PATIENT INFORMATION

NAME:_____

DATE OF BIRTH:_____

SOCIAL SECURITY NUMBER (last 4):_____

ADDRESS:_____ APT #_____

CITY_____ STATE_____ ZIP_____

TELEPHONE NUMBER:_____

2ND ADDRESS:_____ APT #_____

CITY_____ STATE_____ ZIP_____

TELEPHONE NUMBER:_____

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MARRIED____ SINGLE_____ WIDOWED_____ DIVORCED____

YOU WERE REFERRED TO US BY? (circle one)

Internet search | Yelp | Facebook | Natural Awakenings

Drive by | Other Physician_____ Lecture | Friend/Family

E-mail :_____

I request that payment of Medicare/Medigap Benefits be made for any services furnished to me by Richard J. Rimler, DPM. I understand my signature authorizes the release of medical information necessary to pay the claim. Richard J. Rimler, DPM agrees to accept Medicare assignment and many other third party insurances, but I am responsible to pay any deductible and coinsurance, and for non-covered services. I am also responsible for any legal or recovery costs.

SIGNATURE:_____ DATE:_____