Lancaster County Podiatry L.L.P.

Dr. Thomas M. Herrmann
Dr. Steven W. Kreamer
Dr. Peter J. Fodor
Dr. Melissa A. Cavallaro

NEW PATIENT

_____**Address Change** _____**Insurance Change** _____**New Patient**

Last Name:_____ **First Name/MI:**_____

Street:_____ **City/State:**_____ **Zip:**_____

Home Phone:(_____**)** _____**-**_____ **Cell Phone:(**_____**)** _____**-**_____ **Sex: M F**

SS#:_____ **Age:**_____ **Birth date:**_____ **Marital Status: S M D W**

Spouse: _____**Family Physician:**_____**Referred by:**_____

Pharmacy:_____**Email Address:**_____

Responsible Party (if other than the patient) Parent or legal guardian must consent for treatment of minor

Last Name:_____ **First Name/MI:**_____ **Birth date:**_____

Street:_____ **City/State:**_____ **Zip:**_____

Home Phone:(_____**)** _____**-**_____ **Business Phone:(**_____**)** _____**-**_____

PRIMARY INSURANCE INFORMATION:

Insurance Name:_____**Effective Date:**_____
Address:_____**Phone #:**_____
Policy #_____**Group #**_____**Plan #**_____
Subscriber (If other than patient)_____**Date of Birth:**_____
Employer:_____**Phone#**_____

SECONDARY INSURANCE INFORMATION:

Insurance Name:_____**Effective Date:**_____
Address:_____**Phone #:**_____
Policy #_____**Group #**_____**Plan #**_____
Subscriber (If other than patient)_____**Date of Birth:**_____
Employer:_____**Phone#**_____

Authorization to release medical information and assignment of insurance benefits

I request that payment of authorized Medicare, HMO or insurance benefits be made either to me or on my behalf to Lancaster County Podiatry for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents any information needed to determine these benefits or the benefits payable for related services. I authorize Lancaster County Podiatry, its employees, medical providers to release all information from my medical record that may be required for payment of my charges by my insurance company. I understand that I am financially responsible to pay for any charges not covered by other sources.

Patient/Responsible Signature_____Date_____

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