DARLINE KULHAN, DPM, DABFAS, FACFAS

PATIENT INFORMATION:

FIRST NAME:_____MI:_____ LAST NAME:_____

DATE OF BIRTH: _____ Sex: Male..... Female.....

ADDRESS: _____Apt._____

CITY: _____ STATE: _____ ZIP CODE: _____

- CELL PHONE: _____
- WORK PHONE: _____
- HOME PHONE: _____
- What phone # do you prefer we use: Home: ____ Work_____ Cell_____

EMAIL ADDRESS: _____

- Is it acceptable for us to email/text you? Yes..... No.....

Marital States: Single/never married...Married...Partnered...Widowed... Separated...Divorced

Are you Employed: Yes...No...Student....Retired....Child....Other .....

OCCUPATION: _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS:_____phone:_____

EMERGENCY CONTACT:

- FIRST NAME: _____LAST NAME: _____
- Relationship to patient: _____
- EMERGENCY CONTACT PHONE: _____

PRIMARY PHYSICIAN NAME: _____LAST SEEN:_____

ADDRESS: _____phone:_____

PHARMACY NAME: _____

- ADDRESS: _____ phone:_____

HOW DID YOU HEAR ABOUT US?

GOOGLE...WEBSITE...FRIEND/FAMILY...DOCTOR...INSURANCE CO...

ASSIGNMENT AND RELEASE:

I have received information regarding the providers of care in this organization, a copy of the Patient's Bill of Rights and Responsi Information regarding the grievance process and information regarding the infection control process of this organization and I understan all of the information I have received.

I acknowledge that I was provided a copy of the HIPAA Notice of Privacy Practices and that I have read (or had the opportunity t and I understand the Notice.

I certify that I (or my dependent) have (has) the above insurance and assign insurance documents directly to the doctor(s) for servi provided. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor(to release any information necessary to assure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Responsible Party Signature **Date**