RICHARD C. GALPERIN, D.P.M., P.A.
2909 SOUTH HAMPTON ROAD SUITE F132
DALLAS TX 75224
214-330-9299

NEW PATIENT INFORMATION

PATIENT NAME: ____________________

ADDRESS: ____________________

CITY: ____________ STATE: ____________ ZIP: ____________

PHONE: ( ) ____________ SOCIAL SECURITY NUMBER: ____________

CELL: ( ) ____________ E-MAIL: ____________

DATE OF BIRTH: ____________ AGE: ____________ MARITAL STATUS: ____________ SEX: ____________

PATIENT'S EMPLOYER: ____________ PHONE ( ) ____________

ADDRESS: ____________________

CITY: ____________ STATE: ____________ ZIP: ____________

SHOE SIZE: ____________ SHOE WIDTH: N M W WEIGHT: ____________ HEIGHT: ____________

SPORT/OCCUPATION: ____________ USUAL FOOTWEAR: ____________

INSURANCE INFORMATION:

(PLEASE CHECK THE INSURANCE CATEGORY THAT APPLIES)
MEDICARE _______ MEDICAID _______ WORKER'S COMP _______ PRIVATE INSURANCE _______

1) NAME OF PRIMARY INSURANCE COMPANY: ____________________

I. D. #: ____________ GROUP #: ____________

NAME/RELATIONSHIP OF INSURED: ____________ INSURED'S DATE OF BIRTH: ____________

2) NAME OF SECONDARY INSURANCE COMPANY: ____________________

I. D. #: ____________ GROUP #: ____________

NAME/RELATIONSHIP OF INSURED: ____________ INSURED'S DATE OF BIRTH: ____________

IN CASE OF EMERGENCY CONTACT: ____________________

ADDRESS: ____________________

PHONE#: ( ) ____________ RELATIONSHIP ____________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE: ____________________

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN: I HEREBY AUTHORIZE RICHARD C. GALPERIN, D.P.M., P.A. TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY TREATMENT TO MY INSURANCE COMPANY AND TO MY REFERRING DOCTOR. I UNDERSTAND THAT THE METHOD USED TO TRANSMIT INFORMATION MAY BE BY FACSIMILE, U.S. MAIL AND/OR ELECTRONICALLY GENERATED BY COMPUTER. I HEREBY ASSIGN, TRANSFER AND SET OVER TO RICHARD C. GALPERIN, D.P.M., P.A. ALL OF MY RIGHTS, TITLE AND INTEREST TO MY MEDICAL REIMBURSEMENT BENEFITS UNDER MY INSURANCE POLICY WITH: ____________________
____
AUTHORIZING THE PAYMENT OF BENEFITS TO BE MADE DIRECTLY TO RICHARD C. GALPERIN, D.P.M., P.A.

PATIENT SIGNATURE: ____________ DATE: ____________