

Patient Name :	Social Security #:
Address:	City:
	Zip:
Home Phone:	Cellular Phone:
Work Phone:	E-mail Address:
Date of Birth:	Occupation:
Ethnicity:	Marital Status:
Work/School Address:	
Who referred you:	

**Insurance Information:**

Name Primary Insurance Information:
Name Secondary Insurance Information:

**Emergency Contact Information:**

Address:	City:
	Zip:
Home Phone:	Cellular Phone:
Work Phone:	E-mail Address:

**Alternate Address:**

Address:	City:
	Zip:
Home Phone:	Cellular Phone:
Work Phone:	E-mail Address:

**Acknowledge of Receipt of Notice of Privacy Practices**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Please be advised that the following forms are available upon your request:

- Patient Authorization of Release Health Information
- Patient Complaint Form
- Accounting of Disclosures Form
- Request for Correction/Amendment of Health Information
- Restriction Request Form
- Request for Confidential Communication

**LIFETIME SIGNATURE AUTHORIZATION AND INSURANCE PAYMENT ORDER (REQUIRED)**

I authorize the release of my medical information necessary to process my claims. I also authorize any request of payment of medical benefits to DeLand Foot and Leg Center, LLC or treating physician.

Everything I have answered is true, complete, and correct to the best of my knowledge.  
 THIS FORM WILL BECOME A PART OF YOUR PERMANENT MEDICAL RECORD.

Patient Name (print):	Date:
Patient or Guardian's Signature:	