Welcome to our practice

Joaquin Diaz, Jr., DPM 87-08 Justice Ave., Ste. CK Elmhurst, NY 11373

Please take a few minutes to answer the following questions so we can better assist you.

Patient Information

Date_____ Soc.Sec.#_____ Birthdate_____

Name_____
Last Name First Name Initial

Address_____ City_____ State_____ Zip_____

Home phone_____ Cell Phone_____

Sex ( )M ( )F ( ) minor ( ) single ( ) married ( ) separated ( ) divorced ( ) widowed

Employer _____ Business Phone_____

Business Address_____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact?_____ Phone_____

Primary Insurance

Person responsible for account_____

Relationship to patient_____ Birthdate_____ Soc.Sec. #_____

Address_____Home Phone _____

Please Complete Reverse Side

Responsible party employed by _____ Business Phone _____

Business Address_____ Occupation_____

Insurance Company_____ Subscriber ID_____

Insurance address_____Group#_____

Additional Insurance (If Applicable)

Insured Name_____ Relationship to patient _____

Birthdate_____ Soc.Sec.# _____ Home Phone _____

Address _____

Insured employed by _____ Business Phone _____

Insurance Company_____ Subscriber ID_____

Insurance address_____Group#_____

Medical History

1. Are you currently under any treatment?
2. Are you allergic to any medication?
3. Are you Diabetic?
4. Have you been treated by another podiatrist?
5. Current foot complaint:

Assignment and Release

I hereby authorize payment directly to DR. Joaquin Diaz Jr. DPM for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependants. I understand that any delayed unpaid balances will incur a 1.5 percent interest charge monthly to the total amount due.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____