ODIN DE LOS REYES, DPM

Board Certified in Primary Care in Podiatric Medicine

www.drodinreyes.com

NAME_____ _____ _____
FIRST **MIDDLE** **LAST**

PATIENT ADDRESS_____ **APT#**_____

CITY_____ **STATE**_____ **ZIP** _____

HOME PHONE_____ **CELL PHONE**_____

WORK PHONE_____**EXT**_____ **SOCIAL SECURITY NUMBER**_____

EMAIL ADDRESS_____**PREFERRED LANGUAGE** _____

DATE OF BIRTH_____**AGE**_____ **SEX**_____**ETHNICITY** _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED (CIRCLE ONE)

NAME OF EMERGENCY CONTACT _____**PHONE**_____

PRIMARY CARE PHYSICIAN_____**PHONE**_____

ASSIGNMENT OF BENEFITS AUTHORIZATION

I HEREBY ASSIGN PAYMENT OF AUTHORIZED MEDICARE BENEFITS AND ANY OTHER MEDICAL AND/OR SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO BE MADE EITHER TO ME OR ON MY BEHALF TO THIS OFFICE FOR ANY SERVICES FURNISHED TO THIS OFFICE. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE PAID BY MY INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNED TO RELEASE ALL INFORMATION TO SECURE PAYMENT.

WRITTEN ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I CHOOSE) AND UNDERSTAND DR. ODIN DE LOS REYES' NOTICE OF PRIVACEY PRACTICES.

I HAVE READ THE ABOVE INFORMATION AND HEREBY GIVE DR. ODIN DE LOS REYES PERMISSION TO EXAMINE AND TREAT MY FEET.

_____ _____
PATIENT SIGNATURE **DATE**

_____ _____
PARENT OR AUTHORIZED REPRESENTATIVE (IF APPLICABLE) **DATE**