Myers Podiatry Clinic
W. Charles Myers, DPM

Patient Name: _____Social Security #:_____
Address: _____ D.O.B. ___/___/____
City:_____State:_____Zip:_____Phone:_____
Cell #: _____ Alternate #:_____
Emergency Contact: _____ Phone #: _____

Insurance Information

First Insurance:

Only fill out information if insurance is in someone else's name:

(Circle one) Medicare Medicaid Other: _____
Policy #: _____ Group # _____

Private Insurance: (Circle One) Spouse Child Other: _____
Policy Holders Name: _____ D.O.B. ___/___/____
SS #:_____ Policy #: _____

Secondary Insurance:

(Circle One) Medicare Medicaid Other: _____
Policy #: _____ Group #: _____
Insurance under: (circle one) Self Spouse Other:_____
Policy Holders Name:_____ D.O.B. ___/___/____

Insurance Authorization/Receipt of Privacy Practices Notice

I understand in signing this release that my health care provider is authorized to release any information needed for insurance submission, referrals, etc. Also that I am assigning my insurance payment benefit to be paid to the provider and I am responsible for ALL co-payments or coinsurance's not paid by my insurance carrier. I have also received a copy of the Notice of Privacy Practices.

Signature: _____ Date: ___/___/____