



Michael A. Ruiz, DPM  
1444 West 38<sup>th</sup> Street  
Erie, PA 16508

### PATIENT INFORMATION

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Address(street, city, state&zip) \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Cell phone # \_\_\_\_\_ E-mail address \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital status:  Married  Single  Divorced  Widowed  Legally Separated

Family Physician \_\_\_\_\_

Date of last visit with family physician (need month, day and year) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Whom may we contact in case of Emergency? Name & phone number \_\_\_\_\_

### PRIMARY MEDICAL INSURANCE

Carrier Name \_\_\_\_\_ Subscriber Name \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

### SECONDARY MEDICAL INSURANCE

Carrier Name \_\_\_\_\_ Subscriber Name \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

### ASSIGNMENT OF BENEFITS

I hereby authorize the release of any information relating to all claims submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or my dependents, and I will be bound by this signature as though the undersigned had personally signed the particular claim(s). I hereby authorize the insurance company(ies) listed to pay and hereby assign directly to Lake Erie Podiatry all benefits, if any, otherwise were payable to me for services. I understand that I am financially responsible for all charges incurred. I further acknowledge that my insurance benefits, when received by and paid to Lake Erie Podiatry will be credited to my account in accordance with the above said assignment.

Signature

Relationship to Insured

Date