

Welcome to CT Podiatry & Foot Surgery, LLC

This form MUST be COMPLETED, sent back to and RECEIVED at our office at least two days PRIOR to your appointment. This confirms your appointment. Otherwise, we will assume you no longer need your appointment, and the time will be given away.

_____ *I Like to be called:* _____
 Last Name First Name MI

Address _____
 STREET CITY ZIP

Telephone: Home _____ Work _____ Cell: _____

__ Male __ Female ____/____/____ Age ____ __Single __Married __Divorced __Widowed
 Date of Birth

Social Sec # _____ - _____ - _____

Occupation/Employer _____ **Type of work (even if retired)** _____

Who referred you? DR. _____ Friend/Family _____ Phone Book Insurance

Is any member of your family a patient here? _____

Emergency Contact: _____
 Name Relation

Phone: Home _____ Work _____ Cell _____

If guardian needed: _____
 Name Relationship Address Phone

Primary Care Physician: _____ Location _____ Last Visit Date ____/____/____

Your preferred Pharmacy Name and location _____

WHAT IS THE **SPECIFIC REASON** FOR VISIT _____

Please name your insurance(s) in the correct order:

Primary Ins Co. _____
 ID# _____
 Group# _____
 If Insurance is through **ANOTHER** individual:

 Name Relationship To Patient
 Birthdate ____/____/19____
 Address _____

Secondary Ins Co. _____
 ID# _____
 Group# _____
 If Insurance is through **ANOTHER** individual:

 Name Relationship To Patient
 Birthdate ____/____/19____
 Address _____

We welcome you as a New Patient to our practice family. We hope your experience is a beneficial one. At the time our your appointment, you should bring your insurance card (s), as well as a picture identification and be prepared to fill out a medical history simple short form. If you have a long list of medications, you are welcome to bring that instead of writing it again. We ask that at your first visit you arrive approximately 15 minutes prior to your appointment, for paperwork and check-in, otherwise you may take time away from YOUR allotted visit time. We try to allot appropriate time, for more lengthy visits and for 'New Patients'. We do have a long waiting list/cancellation list of people waiting for cancellations, and time for earlier appointments. So, missed or broken appointments hurt everyone. Therefore, we find it necessary to confirm 'New patient' times with people who are actually going to use this time. Otherwise, the time could have been given to another individual.
 Missed appointments or appointments cancelled within a period of less than 24 hours prior to the appointment time will incur a \$50 fee. This is without any connection to any health insurance policy. By signing below, you agree to pay this amount within ten days, from the missed appointment. Payment is to be made via check made out to: CT Podiatry & Foot Surgery, LLC (330 Washington st. #310, Norwich, CT 06360). This is not a medical expense for tax-deductible purposes. We understand that last minute issues arise, and exceptions happen, but we also understand that the telephone was created TWO centuries ago! ☺

The undersigned agrees to all policy written above and that all information is correct.

 Patient or Responsible Party's Signature (and relation to patient) Today's Date

Confirming appointment of:
 ____/____/20____ :15
 Appointment DATE TIME