

Travis Westermeyer, D.P.M.

Podiatric Medicine & surgery

Patient Information

Patient Name _____ Date of Birth _____ Age _____ Sex M F
Last First M.I.

Shoe Size _____ Weight _____ Height _____

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

E-Mail Address _____

Marital Status _____ Driver's License # _____

Name of spouse (or parent if a minor child) _____

Family Doctor _____ Other Physician _____

Have you ever seen a podiatrist before? YES / NO Name _____

In case of emergency contact _____ Phone _____

Nearest relative not living with you _____ Phone _____

Whom may we thank for referring you to our office? Name _____
(Circle one) Physician/ Yellow Pages/ Internet/ Friend/ Family/ Other _____

Employer Information

Employer Name _____ Occupation _____
Business Address _____

Beneficiary Agreement

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status in regards to the above information.

I hereby authorize my insurance/Medicare benefits to be paid directly to Travis Westermeyer, D.P.M. I also authorize the release of any medical, insurance or other information needed for this service in order to assist in the processing of my insurance claim.

Medicare and private insurance carriers may not cover certain services or supplies. In this event I understand that I am responsible for and will be asked to pay for any non-covered services, supplies, co-pays and deductibles at the time of service.

Missed appointments: Unless canceled, at least 24 hours in advanced, our policy is to charge for missed appointments at the rate of \$25.00. Please help us serve you better by keeping scheduled appointments.

Signature _____ Date _____

Signature of Parent or Guardian _____

I acknowledge that I was provided a copy of (or had the opportunity to read) the NOTICE OF PRIVACY PRACTICES.

Initials _____