Today's Date: _____

PATIENT INFORMATION			
First Name:	Middle Name:		Last Name:
Date of Birth:	Age:	Sex: ☐ M ☐ F	Social Sec.#:
Home Address:			
City:	State:	Zip Code:	Email:
Home Phone:	Cell Phone:		Work Phone:
Spouse/Partner:	Phone:		Date of Birth:
Responsible Party:	Phone:		Date of Birth:
Preferred Method of Communication (Please check one): ☐ Home Phone ☐ Work Ph. ☐ Cell Ph. ☐ Email:			May we leave a message? ☐ Yes ☐ No
Race: (optional)	Ethnicity: (optional)	Marital Status: ☐ S ☐ M ☐ D ☐ W	Driver License #:
Occupation:		Employer:	
Employer Address:		Employer Phone:	
Primary Physician:	Phone:		Date last seen:
Referred by:			

IN CASE OF EMERGENCY CONTACT	
Last Name:	First Name:
Relationship:	Phone:

PRIMARY INSURANCE INFORMATION		
Name of Insured:	DOB:	Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insurance Provider:		Phone:
Subscriber #:		Group #:

SECONDARY INSURANCE INFORMATION		
Name of Insured:	DOB:	Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insurance Provider:		Phone:
Subscriber #:		Group #:

PREFFERED PHARMACY			
Name of Pharmacy:		Phone:	
Address(or cross streets):	City:	State:	Zip Code:

I the undersigned, authorize Dr. Jeffrey Klemes to examine and treat my feet medically, surgically, or biomechanically. I hereby assign my insurance benefits to be paid directly to Dr. Klemes and I am responsible for any unpaid balance on co-pays/deductible. I authorize the release of any medical information necessary to process all claims.

SIGNATURE: _____ DATE: _____

GUARDIAN'S SIGNATURE: _____ RELATION: _____

IF PATIENT IS A MINOR (UNDER 18) OR UNABLE TO SIGN OWN CONSENT

BEVERLY HILLS FOOT & ANKLE CENTER

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