

FRANK CHERPACK, D.P.M.
8701 Shoal Creek Blvd. Suite 102
Austin, TX 78757-6809

DATE: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Age: _____ Sex: M F Social Sec. No. _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Wk Phone: (____) _____ Cell: (____) _____

Email: _____

Marital Status: S M D W Race: _____ Driver License No. _____

Patient's Employer: _____ Position: _____

Emergency Contact: _____ Ph No: (____) _____ Relationship: _____

How did you find us? _____ Chief Complaint: _____

Pharmacy: _____ Address: _____ Phone No.(____) _____

Primary Care Physicians: _____ Phone No. (____) _____

INSURANCE INFORMATION

1) NAME OF **PRIMARY** INS CO: _____

NAME OF **POLICYHOLDER**: _____ **POLICYHOLDER'S DOB**: _____

POLICYHOLDER'S SSN: _____ - _____ - _____ **INS GROUP NO.** _____

INSURANCE ID# _____

2) NAME OF **SECONDARY** INS CO: _____

NAME OF **POLICYHOLDER**: _____ **POLICYHOLDER'S DOB**: _____

POLICYHOLDER'S SSN: _____ - _____ - _____ **INS GROUP NO.** _____

INSURANCE ID# _____

PLEASE PRESENT YOUR INSURANCE CARD. Payment is expected at the time service is rendered. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

I hereby assign all medical benefits, including Medicare, private insurance and other plans to Frank Cherpack, D.P.M. I understand that I am financially responsible for all charges whether or not paid by said insurance. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of patient's record.

PATIENT OR AUTHORIZED SIGNATURE: _____ DATE: _____