Jonathan P Sumber, DPM, PC
190 Fair Street
Kingston, NY 12401
845-331-0601

TODAY'S DATE_____

NAME_____

ADDRESS_____

CITY_____STATE_____ZIP CODE_____

DATE OF BIRTH_____ FOOT PROBLEM_____

PHONE #'S _____/_____/_____
HOME CELL-PHONE WORK

RESPONSIBLE PARTY_____

EMERGENCY
CONTACT_____/_____
NAME PHONE NUMBER

PRIMARY INSURANCE_____

SECONDARY INSURANCE_____
PLEASE HAVE YOUR CARDS READY TO COPY

PRIMARY DOCTOR NAME & PHONE_____

PHARMACY NAME & NUMBER_____

MEDICATIONS TAKING_____

_____

PLEASE LIST ANY AND ALL ALLERGIES_____

_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM

ANY PAYMENT OF BENEFITS TO BE MADE TO JONATHAN P SUMBER, DPM

I UNDERSTAND UNDER THE HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT OF 1998, I HAVE CERTAIN PRIVACY IN REGARDS TO PROTECT HEALTH INFORMATION (PHI).

I HERBY CONSENT AND GIVE MY PERMISSION TO JONATHAN P SUMBER, DPM TO ADMINISTER AND PERFORM SUCH PROCEDURES ON ME AS HE DEEMS NECESSARY.

_____/_____
SIGNATURE DATE