

JOHN F. TORREGROSA, D.P.M.,
F.A.C.F.A.S., F.A.C.F.A.O.M.
ANKLE AND FOOT SURGERY

PATIENT INFORMATION

Today's Date _____ Social Security Number _____

Name _____
Last First Middle Initial

Mailing Address _____ City _____ State _____ Zip _____

Local Address _____ City _____ State _____ Zip _____

Home Phone Number _____ Cell Phone Number _____

Date of Birth _____ Age _____ Sex: _____ Male _____ Female

Marital Status _____ Single _____ Married _____ Widowed _____ Divorced _____ Separated

Employer _____ Occupation _____

Employment Address _____

Work Phone Number _____

SPOUSE INFORMATION

Name _____ SSN _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

EMERGENCY CONTACT

In case of emergency, whom should we contact?

Name _____ Phone _____

PRIMARY DR: _____

PH: _____ FX: _____

WORK COMP CARRIER: _____

WORK COMP ADJUSTER _____

PH: _____ FX: _____

WORK COMP NCM: _____

PH: _____ FX: _____

JOHN F. TORREGROSA, D.P.M.,

F.A.C.F.A.S., F.A.C.F.A.O.M.

ANKLE AND FOOT SURGERY

Is this visit accident related? ___Yes ___No Work related? ___Yes ___No

Date of accident/onset_____

PRIMARY INSURANCE

Insurance Company_____

Claims Address_____

Insured's Name_____

Insured's SSN_____ Insured's Date of Birth_____

Policy #_____ Group #_____

SECONDARY INSURANCE

Insurance Company_____

Claims Address_____

Insured's Name_____

Insured's SSN_____ Insured's Date of Birth_____

Policy #_____ Group #_____

I authorize the release of medical information necessary to process this claim or provide prudent medical care either by mail, phone or fax. I also request payment of benefits to be made to the party who accepts assignment.

Patient/Responsible Party Signature

Date

**JOHN F. TORREGROSA, D.P.M.,
F.A.C.F.A.S., F.A.C.F.A.O.M.
ANKLE AND FOOT SURGERY**

CANCELLATION POLICY: WE HAVE A 24 HOUR NOTICE CANCELLATION POLICY.

PRESCRIPTION REFILL POLICY: All patients requiring refills of their medications must notify their pharmacy, who will request a refill from our office. Refill requests require 48 hours notice and are handled at the end of our patient day, so please plan ahead.

I have read and understand the above policies.

Patient/Responsible Party Signature

Date