ELIE C. DANIEL, D.P.M.

Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT

Guarantor Information (to whom statements are sent)

First Name: _____ Middle Initial: ____ Last Name: _____

Address: _____
Street City State Zip

Relationship to Patient: _____ Date of Birth: ____/____/____ Social Sec. No.: _____

Home Phone: _____ Work Phone: _____

Sex: _____ Ethnicity: _____ Patient Email: _____

Pharmacy Information: _____

Patient Referred By: _____

Employer Information

Required by government mandate [although you may refuse]:

Employer Information Language: _____ Employer Name: _____

Employer Address: _____
Street City State Zip

Employer Phone: _____

Patient Insurance Information

Primary Insurance Information

Insurance Plan Name: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____
Street City State Zip

Insurance Plan Phone: _____ Patient's relationship to policy holder: _____

Secondary Insurance Information

Insurance Plan Name: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____
Street City State Zip

Insurance Plan Phone: _____ Patient's relationship to policy holder: _____

To the best of my knowledge the above information is complete and accurate.

Signed_____ Date:_____

*Please sign and date each item below**

ACKNOWLEDGMENT AND AUTHORIZATION:

I have read and understand the HIPAA/Privacy Policy for Elie C. Daniel D.P.M.

Signed_____ Date:_____

I hereby assign my insurance benefits to be paid directly to the healthcare provider

Signed_____ Date:_____

I authorize Elie C. Daniel D.P.M. to release medical information required to process my claim

Signed_____ Date:_____

I have read and understand the Financial Policy for Elie C. Daniel D.P.M.

Signed_____ Date:_____

I authorize Elie C. Daniel D.P.M. to obtain/have access to my medication history

Signed_____ Date:_____

I authorize my provider's office to contact me for my care via Skype, or other social media or messaging or by mobile phone texting, or Telemedicine as needed.

Signed_____ Date:_____

I consent and authorize Doctor Elie C. Daniel or his associate or assistant to do photographing or televising of the operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific, or educational purposes, providing my identity is not revealed by the pictures or by the descriptive text accompanying them into any medium that is deemed necessary. The above named patient, warden, guardian, here by gives up any right for any present or future copyright or royalties from such an endeavor by Dr. Elie C. Daniel and or his associates and or assistants, or assignees.

Signed_____ Date:_____