

CYNTHIA A SINK, DPM

CONFIDENTIAL PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____

RESPONSIBLE PARTY (IF PATIENT IS A MINOR) _____

RESPONSIBLE PARTY DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ SEX _____ MARITAL STATUS _____

HOME PHONE _____ OK TO LEAVE MESSAGE? YES NO

CELL PHONE _____ OK TO LEAVE MESSAGE? YES NO

EMAIL ADDRESS _____

EMPLOYER _____ PHONE _____

EMERGENCY CONTACT _____ PHONE _____

CAN WE GIVE INFORMATION TO EMERGENCY CONTACT? YES NO

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Cynthia Sink DPM to use my Health Care Information and disclose such information to appropriate insurance(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits. I authorize Cynthia Sink DPM to release any information acquired in the course of my examination or treatment to medical and other personnel who may participate in my care. This authorization shall remain valid until I revoke said authorization by giving written notice.

Signature _____ Date _____

AUTHORIZATION OF PAYMENT TO PHYSICIAN:

I hereby assign all insurance benefits directly to Cynthia Sink DPM, if any, otherwise payable to me for the services rendered. I understand that I am financially liable for all services rendered regardless of insurance payment. Cynthia Sink DPM does not wait for settlement from lawsuits. I am responsible for paying for services while in litigation.

Signature _____ Date _____

AUTHORIZATION FOR ALLOWING COMMUNICATION:

I hereby expressly consent to be contacted, by Cynthia Sink DPM or anyone calling on her behalf, for any and all purposes, at any telephone number, or physical or electronic address I provide or which I may be reached, including any wireless telephone number. I agree that Cynthia Sink DPM may contact me in any way, including calls or prerecorded or artificial voice or text messages delivered by an automatic telephone dialing system, or email messages delivered by an automatic emailing system. I expressly acknowledge that this consent cannot be revoked without prior agreement and acceptance by us. I agree to promptly notify us at any time my contact information changes.

Signature _____ Date _____