John P. Beaupied DPM, LLC
PATIENT INTAKE FORM

This information is confidential

PATIENT INFORMATION

Name_____

Address_____

City_____

State_____ Zip_____

Telephone (____) _____

E-mail:_____

Social Security #_____

☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed ☐ Divorced

☐ American Indian or Alaska Native ☐ Asian ☐ White

☐ Black or African American ☐ Native Hawaiian

☐ Hispanic Latino ☐ Other

Date of Birth_____Age_____

Occupation _____

Employer _____

Address _____

_____

Work Phone (____)_____Ext_____

Cell Phone (____)_____

Spouse Information (If Applicable)

Name _____

Home Phone _____

Work Phone _____Ext_____

Primary Physician_____

Referring Physician_____

Office Use Only EHS Pt.#_____

INSURANCE INFORMATION

Primary- Ins. Co. Name_____

Policyholder Name_____

☐ Self ☐ Spouse

Policyholders Date of Birth_____/_____/_____

Employer_____

Secondary- Ins. Co. Name_____

Policyholder Name_____

Policyholders Date of Birth_____/_____/_____

☐ Self ☐ Spouse

PHARMACY INFORMATION

Pharmacy Name_____

Address_____

City_____ State_____

Phone _____

EMERGENCY CONTACT (If other than Spouse)

Name_____

Relationship:_____

Telephone(____)_____

Complete only if patient is under age 18

Name_____

Address_____

City_____

State_____ Zip_____

Telephone ____)_____

SS#_____DOB_____

Occupation_____

Employer_____

Address_____

Work Phone(____)_____Ext_____

John P. Beaupied DPM, LLC
PATIENT INTAKE FORM

Is your treatment today due to:

……..a work related injury ☐ Yes ☐ No Injury Date_____

Do you have written authorization from your employer and comp carrier to be treated ☐ Yes ☐ No

……..a motor vehicle accident ☐ Yes ☐ No Accident Date_____

……..a an accident/ liability case ☐ Yes ☐ No Accident Date_____

WHO REFERRED YOU TO OUR OFFICE: ☐ Internet/Google ☐ Friend/Family ☐ Physician ☐ Insurance ☐ Other

***If Other* - NAME/SOURCE of referral:_____**

PERMISSION FOR TREATMENT:

I hereby give permission to Dr. John P. Beaupied/Dr. Phillip F. Morreale to administer treatment and perform such general procedures as he may deem necessary in the diagnosis and/or treatment of my foot condition.

SIGNATURE OF INSURED OR AUTHORIZED PERSON_____DATE_____

INSURANCE RELEASE:

I hereby authorize the release of any medical information pertaining to my treatment or information necessary for processing insurance claims and payment of medical benefits to myself or the party who accepts assignments. This authorization will remain valid until revoked by me in writing. I understand that I am legally responsible for all charges whether or not reimbursed by my insurance company.

SIGNATURE OF INSURED OR AUTHORIZED PERSON_____DATE_____

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf of JOHN P. BEAUPIED DPM, LLC for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

<table>
<tr><th colspan="2">PATIENT'S NAME (Please Print)</th><th>PROVIDER: Name, Address, and Zip</th></tr>
<tr><td colspan="2"></td><td rowspan="4">John P. Beaupied DPM. LLC
6420 W. 127th ST STE 105
Palos Heights, IL 60463</td></tr>
<tr><td colspan="2">PATIENT'S SIGNATURE</td></tr>
<tr><td>PATIENT'S MEDICARE NO.</td><td>DATE</td></tr>
<tr><td></td><td></td></tr>
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