

DR. JOHN A. CICCONE, DPM
PODIATRIST AND FOOT SURGEON

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EL CAJON, CA. 92021
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SAN DIEGO, CA. 92109
(858) 272 -5910

PATIENT INFORMATION

NAME _____ SOCIAL SEC# _____
Last First MI.

ADDRESS _____

CITY _____ STATE _____ ZIP _____ TEL _____

SEX M F AGE _____ BIRTHDAY ____ / ____ / ____ MARITAL STATUS M S D W
m d y

PERSON FINANCIALLY RESPONSIBLE _____ PHONE _____

ADDRESS _____ RELATIONSHIP _____

PATIENT/RESPONSIBLE PARTY EMPLOYED BY _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

EMERGENCY NOTIFICATION PERSON? _____ PHONE _____

PRIMARY INSURANCE

PRIMARY INSURED ON ACCOUNT _____

RELATIONSHIP TO PATIENT _____ BIRTHDAY ____ / ____ / ____ SOCIAL SEC.# _____
Last Name First Name Middle Initial

INSURED EMPLOYED BY _____ BUSINESS PHONE _____

BUSINESS ADDRESS _____

INSURANCE COMPANY NAME _____ PHONE _____

INSURANCE COMPANY ADDRESS _____

SUBSCRIBER I.D.# _____ GROUP# _____ STUDENT?? YES NO

ADDITIONAL INSURANCE

IS PATIENT COVERED BY ADDITIONAL INSURANCE? YES NO (CIRCLE ONE)

INSURANCE NAME _____ SUBSCRIBER _____ BIRTHDATE _____

RELATIONSHIP TO PATIENT _____ PHONE _____ SUBSCRIBER ID _____

INSURANCE ADDRESS _____ GROUP# _____

ASSIGNMENT AND RELEASE

I THE UNDERSIGNED CERTIFY THAT I OR MY DEPENDENT HAVE INSURANCE COVERAGE WITH THE ABOVE NAMED COMPANY AND ASSIGN DIRECTLY TO DR. CICCONE ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR RENDERED SERVICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE EVEN IF INSURANCE PROMISED TO PAY. I AM RESPONSIBLE FOR FEES AND COLLECTION FEES IN ADDITION, IF NEED BE. I AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT AND AUTHORIZE THE USE OF MY SIGNATURE TO OBTAIN PAYMENT ON INSURANCE SUBMISSIONS. ** I AM GIVING DR. CICCONE PERMISSION TO EXAMINE AND TREAT MY FEET AND ANKLES MEDICALLY AND /OR SURGICALLY AND HAVE PROVIDED THE ABOVE INFORMATION COMPLETELY AND TO THE BEST OF MY KNOWLEDGE AND I AM RESPONSIBLE FOR ANY OMISSIONS. I ALSO ACKNOWLEDGE THE OFFER OF A HIPAA POLICY BROCHURE. I AGREE TO 24 HOURS NOTICE FOR MISSED APPTS OR THERE WILL BE A \$25. FEE. SIGNATURE _____ DATE _____