Dr. Charles Perry
Podiatric Medical Specialist
1354 Clark St
Cambridge, OH 43725

First Name_____M.I._____Last_____

Address_____City_____State_____Zip Code_____

Date of Birth_____Social Security Number_____

Phone Number_____Cell Phone Number_____

Today's Date_____Marital Status Married Single Divorced Widow (Circle One)

Race: White_____Black or African American_____Asian_____Other_____(Please List)

Ethnicity Hispanic or Latino___ Not Hispanic or Latino___ Language_____E-Mail_____

Family or Primary Doctor_____Pharmacy_____

Emergency Contact (Name)_____Phone Number_____

For Minor Patients:

Parent/Legal Guardian Name:_____

Parent/Legal Guardian Social Security Number:_____

Parent/Legal Guardian Date of Birth: _____

PRIMARY INSURANCE

Insurance Company_____

Insured Name_____

Relationship to Patient_____

Insured Social Security Number_____

Insured Date of Birth_____

SECONDARY INSURANCE

Insurance Company_____

Insured Name_____

Relationship to Patient_____

Insured Social Security Number_____

Insured Date of Birth_____

Patient Authorization For Use And Disclosure Of Protected Health Information

I hereby authorize Podiatric Medical Specialists to use and/or disclose any and all Protected Health Information (PHI) about me to the following persons:

Name_____Relationship_____

Name_____Relationship_____

I hereby give physicians at Podiatric Medical Specialists permission to examine and treat my feet and/or ankles.

Signature_____Date_____