

Dr. Charles Perry
Podiatric Medical Specialist
1400 Brandywine Boulevard
Zanesville, OH 43701

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 _____