Brian O'Carroll, DPM

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1525 E Main St, Ste B, Santa Maria, CA 93454 t: (805) 354-7990 f: (805) 354-7009

PATIENT INFORMATION

Patient Name (Last): _____ First: _____ M.I.: _____

Gender: ☐ M ☐ F Date of Birth: _____ SS#: _____

Preferred Office: ☐ Pismo Beach Office ☐ Santa Maria Office

Street Address: _____

City: _____ State: _____ Zip: _____

Home Ph: _____ Cell: _____ Work Ph: _____

Email: _____

Preferred Phone: ☐ Home ☐ Work ☐ Cell

☐ Consent to leave messages regarding your care or balance

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Partner ☐ Other

Employer: _____ Occupation: _____

Emergency Contact

Name: _____ Relationship: _____

Home Ph: _____ Cell: _____

INSURANCE

PRIMARY Insurance Company: _____ Subscriber ID #: _____ Group/Policy #: _____

SECONDARY Insurance Company: _____ Subscriber ID #: _____ Group/Policy #: _____

If someone other than the patient is responsible for payment (such as in the case of a minor), this person is called the Guarantor. Please provide the GUARANTOR information below.

Relationship to Patient: _____ Date of Birth: _____

Guarantor's Name (Last): _____ First: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Ph: _____ Work Ph: _____ Cell: _____

Assignment of Benefits: I hereby authorize my insurance carrier(s), including Medicare, to issue payment directly to the above provider for medical services and associated supplies. I understand that I am responsible for amounts not covered by insurance, including co-payments, deductibles, and non-covered items.

Patient/Guardian Signature: _____ Date: _____