Carlsbad – Encinitas Podiatry

Ronald Lieberman, D.P.M.

Podiatric Medicine & Surgery

PATIENT INFORMATION

Patient Name_________________________________ Date of Birth ________________
(First) (M.I.) (Last) (Month/Day/Year)

Address____
(Street) (City) (State) (Zip)

Home Phone_________________________ Cell Phone _________________________

Sex M F Marital Status _______ SS# ___________ Driver License #__________
Person responsible for the bill ____
Name of spouse (or parent if a minor child) ___________________________________
In case of emergency – contact _____________________ Phone ________________
Whom may we thank for referring you to our office? Name _____________________
(circle one) Physician/Yellow pages/Website/Friend/ Family/ Other _____________________

EMPLOYER INFORMATION
Patient Employer ______________________ Business Phone _____________
Business Address ____
Occupation ____

INSURANCE INFORMATION
Primary Insurance Carrier ______________________Phone ______________
Insured's ID # ______________________ Group # _____________________
Subscriber Name ____________________ Relation to Patient ____________
Secondary or Supplemental Insurance______________________________
Insured's ID # ____
Subscriber Name ____________________Relation to Patient _____________

BENEFICIARY AGREEMENT
I hereby authorize my insurance/Medicare benefits to be paid directly to Ronald Lieberman, D.P.M. I also authorize the release of any medical, insurance or other information needed for this service in order to assist in the processing of my insurance claim.

Medicare and private insurance carriers may not cover certain services or supplies. In this event I understand that I am responsible for and will be asked to pay for any non-covered services, supplies, co-pays and deductibles at the time of service.

Cancellations or broken appointments without 24 hours notice will be subject to an office visit charge.

___________________________________ ______________________
Signature Date