Darryl E. Burns, DPM

Diplomate

American Board of Podiatric Surgery

951 Blanco Circle
Suite E
Salinas, CA 93901

(831) 422-0442

Name: _____ Social Security# _____

Address: _____ City_____ STATE__ PHONE#_____

ZIP CODE_____ DATE OF BIRTH_____AGE: _____ Male: _____ Female: _____

Employer_____ YOUR WORK PHONE# _____

SPOUSE'S EMPLOYER_____ SPOUSE WORK #_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

E-mail Address: _____

Is this problem related to: _____ EMPLOYMENT _____ ACCIDENT

FAMILY PHYSICIAN _____ DATE LAST SEEN _____

ALLERGIES: _____

MEDICINES YOU AREN'T ABLE TO TAKE: _____

WHOM MAY WE CONTACT IN CASE OF EMERGENCY?

_____ PHONE # _____

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING INFORMATION REGARD ING THE RESPONSIBLE PARTY:

NAME: _____ WORK PHONE # _____

SOCIAL SECURITY # _____ SPOUSE NAME _____

PRIMARY INSURANCE _____ DO YOU HAVE A CO-PAY? _____

HAVE YOU MET YOUR DEDUCTIBLE? _____

SECONDARY INSURANCE _____

PLEASE HAND YOUR INSURANCE CARDS TO THE RECEPTIONIST SO WE MAY COPY THEM

I authorize use of this form on all my insurance submissions. I authorize release of information to all my insurance companies. I understand that I am responsible for my bull. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I authorize payment direct to my doctor. I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____

Darryl E. Burns, D.P.M.

SURGERY, MEDICINE & INJURY OF FOOT AND ANKLE

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES AND OFFICE POLICY

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have (or had the opportunity to read if I so chose) and understand the Notice.

It is my responsibility to furnish Dr. Burns any Medical benefits that I have both primary and secondary.

If I am unable to provide the necessary information within 72 hours after my appointment it will then be my responsibility to pay for services in full and submit for reimbursement from my insurance company on my own.

OUR OFFICE DOES NOT TAKE MEDI-CAL INSURANCE

If you require any forms to be filled out, our fees are as follows:

Surgery patient's one form as a courtesy
All other forms $15.00 payable in advance

We no longer accept the responsibility of faxing or mailing forms, you will have to pick them up from our office upon completion.

_____ _____

Patient Name (print) **Date**

_____

Parent or Authorized Representative

_____

Signature