FRANK CHERPACK, D.P.M.
8701 Shoal Creek Blvd. Suite 102
Austin, TX 78757-6809

DATE: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Age:_____ Sex: M F Social Sec. No. _____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Wk Phone: (_____)_____ Cell: (_____)_____

Email: _____

Marital Status: S M D W Race: _____ Driver License No. _____

Patient's Employer:_____ Position:_____

Emergency Contact:_____ Ph No: (____)_____ Relationship:_____

How did you find us? _____ Chief Complaint:_____

Pharmacy: _____Address: _____Phone No.(____)_____

Primary Care Physicians: _____ Phone No. (____)_____

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INSURANCE INFORMATION

1) NAME OF **PRIMARY** INS CO: _____

NAME OF **POLICYHOLDER:** _____**POLICYHOLDER'S** DOB**:**_____

POLICYHOLDER'S SSN:_____-_____-_____INS GROUP NO**.**_____

INSURANCE ID# _____

2) NAME OF **SECONDARY** INS CO**:** _____

NAME OF **POLICYHOLDER:** _____ **POLICYHOLDER'S** DOB**:**_____

POLICYHOLDER'S SSN: _____-_____-_____INS GROUP NO. _____

INSURANCE ID# _____

PLEASE PRESENT YOUR INSURANCE CARD. Payment is expected at the time service is rendered. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

I hereby assign all medical benefits, including Medicare, private insurance and other plans to Frank Cherpack, D.P.M. I understand that I am financially responsible for all charges whether or not paid by said insurance. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of patient's record.

PATIENT OR AUTHORIZED SIGNATURE: _____DATE: _____