

DR.DAVID J. FREEDMAN, D.P.M., P.A./Ambulatory Foot & Ankle Center,Inc.

DR. DAVID J. FREEDMAN-DIPLOMATE, AMERICAN BOARD OF PODIATRIC SURGERY
CERTIFIED IN FOOT SURGERY
FELLOW, AMERICAN COLLEGE OF FOOT & ANKLE SURGEONS

LEISURE WORLD PLAZA PROFESSIONAL BUILDING
3801 INTERNATIONAL DRIVE - SUITE 204
SILVER SPRING, MARYLAND 20906
TELEPHONE (301) 598-0130

PATIENT REGISTRATION:

Last Name : _____ Sex: M / F Height : ____ Weight : _____

First Name : _____ Middle Initial : _____ Marital Status : S M D W Shoe Size: _____

Address : _____ Birth Date ____/____/____ Age: _____

City : _____ Occupation : _____

Home Phone : () _____

Cell Phone : () _____

State : _____ Zip Code : _____ Work Phone : () _____

Extension : _____

Referral : _____ Social Security #: _____

(How did you hear about our office?) _____

Financially Responsible Person: _____ Social Security #: _____

Address: _____ Work Phone : () _____

Place of Employment: _____

PRIMARY INSURANCE COVERAGE :

Ins. Company : _____

Insured Name : SAME AS ABOVE Y or N OTHER : _____ Their Date of Birth _____

Relationship : SELF SPOUSE CHILD OTHER : _____

Co-payment : \$ _____

Policy Number : SAME AS SOCIAL SECURITY NUMBER OTHER : _____

Group Number : _____

Employer : _____

SECONDARY INSURANCE COVERAGE :

Ins. Company : _____

Insured Name : SAME AS ABOVE Y or N OTHER : _____ Their Date of Birth _____

Relationship : SELF SPOUSE CHILD OTHER : _____

Co-payment : \$ _____

Policy Number : SAME AS SOCIAL SECURITY NUMBER OTHER: _____

Group Number : _____

Employer : _____

PATIENT'S AUTHORIZATION :

I hereby authorize the processing of the medical insurance either by electronic or manual method by DR DAVID J FREEDMAN DPM PA or Ambulatory Foot & Ankle Center, Inc.. My signature authorizes payment of all major medical and/or surgical benefits to which I am entitled from the listed insurer(s) above to pay DR DAVID J FREEDMAN DPM PA or Ambulatory Foot & Ankle Center, Inc.. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I recognize my financial obligation of any balance, co-insurance, deductible, and non-covered services that may be required.

Signature of Subscriber or Beneficiary

Date