**PATIENT INFORMATION**

UNIVERSITY PODIATRY ASSOCIATES
BENNETT L. WOLANSKY DPM, PA
4601 S UNIVERSITY DR
DAVIE, FL 33328

NAME_____DATE OF BIRTH_____/_____/_____

RESPONSIBLE PARTY_____

HOME ADDRESS_____

CITY_____ZIP CODE_____ SEX M F

HOME TELEPHONE_____MARITAL STATUS_____

E-MAIL ADDRESS_____

EMPLOYER_____OCCUPATION_____

ADDRESS_____WORK PHONE_____

CITY_____ZIP CODE_____

INSURANCE CO_____

POLICY #_____GROUP #_____

DRIVERS LICENSE #_____PREVIOUS PODIATRIST_____

REFERRED BY_____FAMILY M.D._____

DESCRIPTION OF PROBLEM_____

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PLEASE NOTE: I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION OR OTHER INFORMATION NEEDED FOR THE PROCESSING OF THE ATTACHED MEDICAL CLAIM AND REQUEST THAT PAYMENT BE MADE DIRECTLY TO THE TREATING DOCTOR. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. IT IS UNDERSTOOD THAT THE PATIENT IS RESPONSIBLE FOR THE MEDICAL SERVICES THEY RECEIVE.

DATE_____

SIGNATURE_____
(PARENT SIGNATURE IF PATIENT IS A MINOR)