DIPLOMATE, AMERICAN BOARD OF PODIATRIC SURGERY
BOARD CERTIFIED IN FOOT AND ANKLE SURGERY
DIPLOMATE, AMERICAN BOARD OF PODIATRIC ORTHOPEDICS
AND PRIMARY PODIATRIC MEDICINE

L. CRAIG SEMER, DPM, FACFAS, FACFAOM

FOOT AND ANKLE SURGEON • PODIATRIST

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(954) 474-FOOT (3668)

PLEASE COMPLETE ENTIRE FORM AS THIS IS A PERMANENT RECORD

Do you understand spoken and written English? ___Yes ___No. If not, what is your most comfortable language?_____.

Patient ( ) Mr.
( ) Mrs.
( ) Miss

First Name _____ Middle Name _____ Last Name _____ Initial

Florida Address

Street _____ Apt. # _____ Phone #

City _____ State _____ Zip Code

Out of State Address

Street _____ Apt. # _____ Area Code &Phone #

City _____ State _____ Zip Code

Personal

Age _____ Date of Birth _____ Place of Birth _____ SS#

Name of Spouse

Check One: ( ) Married ( ) Divorced ( ) Widowed ( ) Single

Name of person legally responsible for payment (if patient is a minor, name of parent or guardian)

If patient is a minor:

Father's Name (Address if different than patient)

Mother's Name

Insurance: Do you have medical or surgical insurance: ( ) Yes ( ) No

Medicare # _____
Please include letter following social security number

Medicaid # _____
Cardholder Name Include Patient's suffix number

Do you have Medicare Supplemental Insurance? ( ) Yes ( ) No

If you do not have supplemental insurance coverage you are responsible for the 20% not covered by Medicare. Accepting assignment means that we accept payment from Medicare for the 80% of the charges they cover.

SOURCE OF REFERRAL

Whom may we thank for referring you to this office? _____

I understand that I am personally responsible for any charges incurred for my treatment.

_____
Patient's Signature (parent - guardian)

Patient's Supplemental Insurance

Cardholder's Name | Policy #

Insurance Company Name

Street Address

City | State | Zip Code

Patient's Employment Information

Patient's Employment | Name of Company

Street Address

City | State | Zip Code | Phone #

Insurance Information

Insurance Company | Policy #

Street Address

City | State | Zip Code | Phone #

Does your spouse have Health Insurance Coverage: If yes, complete below.

Spouse

Name of Employer

Street Address | Phone #

City | State | Zip Code

Spouse's Insurance Information

Name of Company | Policy #

Street Address | Phone #

Street Address | City | State | Zip Code

Auto Insurance

Name of Insured | Policy #

Name of Insurance Company

Street Address | City | State

Comp Information

Name of Insurance Company | Policy #

Street Address | City | State | Zip Code