Welcome To The Office Of Dr. Deanna Chapman!

Name: _____ Date of Birth: _____
Age: _____ Sex: F ___ M ___ Social Security Number: _____
Single _____ Married _____ Divorced _____ Separated _____ Widowed _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____
Employer: _____ Occupation: _____
Work Phone: _____
Primary Language: _____ Ethnicity: Hispanic _____ Not Hispanic _____
Emergency Contact: _____
Relationship To You: _____ Phone Number: _____
Primary Care Physician: _____ Contact Number: _____
Diabetic Physician (if applicable): _____
Who Referred You To Our Office: _____
Preferred Pharmacy: _____
City: _____ Zip Code: _____
Primary Concern Foot Concern: _____

Primary Insurance

Insurance Company: _____
I.D. Number: _____ Group Number: _____
Primary Card Holder For Account: _____
Relationship: _____ Date of Birth: _____

Secondary Insurance

Insurance Company: _____
I.D. Number: _____ Group Number: _____

I HAVE INSURANCE AND ASSIGN DIRECTLY TO DR. DEANNA CHAPMAN ALL INSURANCE BENEFITS. IF ANY, OTHERWISE PAYABLE FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES; WHETHER OR NOT PAID BY YOUR INSURANCE. I, HEREBY, AUTHORIZE DR. DEANNA CHAPMAN TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

Signature: _____ Date: _____

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF, AND PROVIDE INDIVIDUALS WITH THIS NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECT HEALTH INFORMATION. I AM AWARE OF MY HIPAA PATIENT PRIVACY RIGHTS AND A COPY OF THE HIPAA NOTICE OF PRIVACY PRACTICES HAS BEEN OFFERED TO ME.

Signature: _____ Date: _____