Bruce D. Gorlick, D.P.M., FACFAS
Diseases and Surgery of the Foot and Ankle
Diplomate, American Board of Podiatric Orthopaedics
And Primary Podiatric Medicine
Diplomate, American Board of Podiatric Surgery
Fellow, American College of Foot and Ankle Surgeons
3939 J Street, Suite 200
Sacramento, California 95819

PATIENT INFORMATION

(This information is necessary for our files and considered confidential)

Patient Name:____
(Last) *(First)* *(Middle)*

Birthdate:____/____/____ Age:______________

______________________________________Relationship:_________________________
(***If patient is minor, give name of parent or legal guardian***)

Residence Address:____
(Street Address City State Zip)

Patient is: ( ) Married ( ) Single ( ) Divorced ( ) Widowed ( ) Other

Driver's License#:______________ Social Security#:___/___/____ Phone#:___________

E-Mail Addresses:____

Employer:____How long?_______________

Business Address:____
(Street Address City State Zip)

Occupation:________________________________ Business Phone#__________________

Spouse or Significant Other:____

Employed by:____Phone #:_______________

Business Address:____

In Case of Emergency, contact:____

Address:____

Relationship:____________________________________ Phone #:___________________

____ ______________________________
(Signature) *(Date)*

IMPORTANT: SEE BACK OF PAGE, READ CAREFULLY, AND SIGN

Assignment and Release

Assignment of Insurance Benefits: I hereby authorize Bruce D. Gorlick, D.P.M., FACFAS to release any and all medical information to the insurance carrier(s) named on my patient information, its successors or assigns for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization. I have read this authorization and understand it. I hereby assign to Bruce D. Gorlick, D.P.M., FACFAS all money to which I am entitled for medical and/or surgical expenses relative to the services rendered by him, but not to exceed my indebtedness to said physician and/or surgeon. It is understood that any money received from the insurance company (ies) listed over and above my indebtedness will be refunded to me when my bill is paid in full. A photocopy of this Assignment shall be considered as effective as the original.

I hereby instruct and direct the insurance company (ies) named in my patient information to pay by check made out and mailed to:

Bruce D. Gorlick, D.P.M., FACFAS
Mercy Medical Plaza~South
3939 J Street, Suite 200
Sacramento, California 95819
(916) 733-6874

~or~

If my current insurance policy prohibits direct payment to the Doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

____
(Patient Name)

C/O Bruce D. Gorlick, D.P.M., FACFAS
Mercy Medical Plaza~South
3939 J Street, Suite 200
Sacramento, California 95819
(916) 733-6874

Unless claims filed with my insurance company are paid or denied within 30 days, I understand that a formal written complaint will be filed with the Insurance Commissioner of the State of California. I give my consent to this written filing.

______________________________________ ______________________
(Signature of Patient or Legal Guardian) *(Date)*