RICHARD D. WOLFF, DPM DBA: ADVANCED FOOT CARE

PATIENT CONTACT INFORMATION YEAR _____

I, _____give permission for correspondence in the following manner and I acknowledge it is my responsibility to keep my contact information current (Phone, Address, Insurance info).

Name_____Birthdate_____

Address_____
Street City Zip
Is this your billing address: Yes No
If different, billing address is:

_____
Street City Zip

Telephone: Please circle one that we should use as main contact number
Home _____Cell_____
Work_____Other_____

Messages can be left with detailed information yes_____no____

Or Leave only call back information yes_____no____

EMERGENCY CONTACT WITH PHONE#: _____

I permit my personal health information to be discussed with the following individuals:

Name: _____relationship_____Phone_____

Name: _____relationship_____Phone_____

Name: _____relationship_____Phone_____

Patient signature_____Date_____
If signed by patient's authorized representative, describe the representative's authority:
____ Patient is a minor; I am the patient's parent and natural guardian
____ Patient is a minor; I am the patient's guardian, appointed by the Court of _____
____ Patient is a ward; I am the patient's guardian, appointed by the Court of _____
____ The patient is deceased: I am the surviving spouse, or executor or administrator of the patient' s estate, appointed by _____County Probate Court.
____ I am the patient's attorney in fact, designated in the patient's DPA for Healthcare.
____ Other