Neal A. Marks, D.P.M., F.A.C.F.A.S.
Heather A. Craig, D.P.M.
William J. Scott, D.P.M.

Rocky River Office • 2880 Plymouth Avenue **South Euclid Office** • 4338 Mayfield Road

Podiatric Record • *This record is confidential*

Patient's Name ______________________________ ☐ M ☐ F
Last First Initial

Address ______________________________

City ______________ State ______________ Zip ______________

Social Security No. ______________ Age ______________ Date of Birth ______________

Home Phone (_____) ______________ Work Phone (_____) ______________

Employer ______________ Cell Phone (_____) ______________

Spouse/Guardian ______________________________

Name and phone no. of emergency contact ______________________________

How did you hear of our office? ______________________________

Medical Insurance: Yes No ***Please have insurance card(s) available.***

Subscriber Name ______________ Policy No. ______________

Group No. ______________ Insurance Company ______________

Supplementary Coverage: Subscriber Name ______________________________

Policy No. ______________ Group No. ______________ Company ______________

Is there someone we may talk to about your medical concerns if we cannot reach you?

Name ______________ Phone ______________ Relationship ______________

May we leave a message at your home with other residents, on voicemail and answering machine regarding appointments? Yes ______ No ______

May we send reminder cards in the mail for your appointments? Yes ______ No ______

May we take pictures of your condition for documentation purposes? Yes ______ No ______

I hereby give Drs. Marks, Craig and Scott or their associates permission to examine and treat my foot and ankle.

Patient/Guardian Signature ______________________________ **DATE** ______________

ALL PATIENTS:

I UNDERSTAND THAT DR. MARKS, DR. CRAIG, DR. SCOTT OR THEIR ASSOCIATES WILL SEND MY CLAIMS TO MY INSURANCE COMPANY FOR PAYMENT. I ALSO UNDERSTAND THAT IF MY INSURANCE COMPANY DOES NOT PAY OR IF PAYMENT IS APPLIED TO MY DEDUCTIBLE OR CO-PAYMENT, I WILL BE RESPONSIBLE FOR THE BALANCE. I ALSO UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ANY REFERRALS THAT ARE NEEDED FROM MY PRIMARY DOCTOR.

ALSO, I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIMS. I REQUEST PAYMENT OF BENEFITS TO DR. NEAL MARKS, DR. HEATHER CRAIG, DR. WILLIAM SCOTT OR THEIR ASSOCIATES AND/OR NEAL A. MARKS, D.P.M., INC.

SIGNED ______________________________ **DATE** ______________