Foot HealthCare of Delaware

Patient Information

Name _____ Social Security _____

Address _____

City _____State _____Zip Code _____

Telephone _____Cell Phone _____

Email address _____ Date of Birth _____

Emergency Contact _____Phone _____

Primary Care Physician _____Phone _____

Insurance Information

Primary _____ ID # _____

Address _____ Group _____

_____ Telephone _____

Secondary _____ ID # _____

Address _____ Group _____

_____ Telephone _____

Authorization

I authorize Dr. Gina M. Freeman to provide podiatric medical services to the above named patient. I authorize my insurance company to pay to the doctor all benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the doctor to release all information necessary to secure payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____Date_____

615 West 18th Street Wilmington, DE 19802 302-765-2505