Felix Sigal, D.P.M.
PODIATRIC SURGERY
3875 WILSHIRE BLVD., SUITE 307
LOS ANGELES,CA 90010
PHONE : (213) 365-0793
FAX: (213) 365-0794

PATIENT INTRODUCTION DATE________________________

□Mr.
□Mrs.
□Miss.____AGE________________
FIRST MIDDLE LAST

BIRTHDATE_______________________

□SINGLE □MARRIED □SEPARATED □DIVORCED □WIDOWED

NAME OF PERSON LEGALLY RESPONSIBLE
(IF PATIENT IS A MINOR, NAME OF PARENT OR GUARDIAN, ETC)____

HOME ADDRESS____
STREET APT CITY ZIP

HOME PHONE_________________________ SOCIAL SECURITY___________________________

CELL PHONE___________________________ DRIVERS LICENSE _________________________

PATIENT EMPLOYED BY______________________________OCCUPATION__________________________PHONE ___________________

NAME OF SPOUSE____AGE______________
FIRST MIDDLE LAST

SPOUSE EMPLOYED BY________________________________OCCUPATION________________________PHONE____________________

EMERGENCY CONTACT____PHONE ________________________

REFERRED BY____
FULL NAME

ADDRESS____PHONE ______________________________

ASSIGNMENT OF BENEFITS:
I assign all insurance benefits to Dr. Felix Sigal. I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that Dr. Felix Sigal's office is not responsible to know my plan, what it will pay for, or deductible requirements. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I hereby give my consent for examination, treatment, and insurance billing. I authorize appointment confirmations to be left with any family member or on the answering machine (in the event that I am not at home.)
ALL IN COMPLIANCE WITH HIPPA

DATE____________________________ SIGNATURE______________________________________

ACKNOWLEDGMENT OR RECEIPT OF NOTICE OF PRIVACY PRACTICES

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS MEDICAL PRACTICE'S NOTICE OF PRIVACY PRACTICES. I FURTHER ACKNOWLEDGE THAT I WILL BE OFFERED A COPY OF ANY AMENDED NOTICE OF PRIVACY PRACTICES.

SIGNATURE: ____ DATE: ______________________
PATIENT/RESPONSIBLE PARTY

PRINT NAME: ______________________________________

IF NOT SIGNED BY THE PATIENT, PLEASE INDICATE:

RELATIONSHIP: ____

NAME OF PATIENT: ______________________________________

List all medications you are currently taking:

1.
2.
3.
4.
5.
6.
7.
8.

Allergic to any medication(s)?

NO _____
YES – PLEASE DETAIL: