Michael C. Piccarelli, DPM
Board Certified in Foot Surgery/ Reconstructive Rearfoot & Ankle Surgery
Fellow, American College of Foot & Ankle Surgeons
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PATIENT INFORMATION

*NAME_____ SS#_____-_____-_____
*DATE OF BIRTH____/____/____
*ADDRESS_____
*CITY_____ STATE_____ ZIP CODE_____
*TELEPHONE: HOME ( )_____ WORK ( ) _____
CELL ( ) _____
*E-MAIL ADDRESS_____
*PHARMACY_____
ADDRESS & PHONE OF PHARMACY_____
_____
OCCUPATION_____
EMPLOYER / ADDRESS / TELEPHONE
_____ ( )_____
HOW WERE YOU REFERRED? _____

INSURED PERSON (IF DIFFERENT THAN PATIENT)
NAME_____ RELATIONSHIP_____
DATE OF BIRTH____/____/____ SS#_____-_____-_____
EMPLOYER_____ TELEPHONE ( )_____

MEDICAL INFORMATION RELEASE / ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of the authorization to be used in place of the original.
Signature X_____ Date ____/____/____

I hereby authorize Dr. Piccarelli to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment from my insurance company be made to Dr. Piccarelli or to the party that accepts assignment.

I also agree that I am responsible for the fee of any services that are not covered by my carrier or any deductible that may apply. _____ (initial)

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.
Signature X _____ Date ____/____/____