Douglas A. Ehrenberg, D.P.M.
52 Mohawk Avenue
Corte Madera, California 94925
(415) 385-7587
www.wellfeet.com
Podiatry

Name:_____ Phone (H):_____

Address:_____ Phone (C):_____

City:_____ State:_____ Zip code:_____

Birthdate:_____ Age: _____ Occupation:_____

Is it ok to leave health related messages on your:
Home phone Yes / No
Cell Phone voice Yes / No
Cell Phone Text messages Yes / No

Is there an email address you would like to put in our system? Yes / No

If yes, please list:_____

Ethnicity: Caucasian/Hispanic/Asian/Black Primary Language Spoken: _____

Medical Information:

Height:_____Weight:_____

Personal physician: _____

Please list any drug allergies:_____

Tobacco Use? No / Yes If yes number of years_____

Please list any medications with dosage you are taking:

_____

_____

Please list any medical conditions and/or recent illnesses or hospitalizations:_____

_____

I hereby give permission to Douglas A. Ehrenberg, D.P.M. to: administer treatment, and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition, I understand that I am responsible for any financial obligation incurred during my diagnosis and treatment.

Signature:_____Date_____

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Acknowledgement of Receipt of Notice

I understand that Douglas Ehrenberg, D.P.M. may share my health information for treatment, billing and healthcare operations. I have been given a copy of his **notice of privacy practices** that describes how my health information is used and shared. I understand the organized healthcare arrangement has the right to change this notice at any time. I may obtain a current copy by contacting his office. My signature below constitutes my acknowledgement that I have been provided with a copy of the notice of privacy practices.

_____ _____

Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient

_____

Assignment of Benefits

I assign and authorize my insurance company to have all payments made directly to Dr. Ehrenberg for his visits. In lieu of my signature on the insurance claim form for each visit, I have elected to sign this form today so that future claims may be submitted with "signature on file" .

Patient's Signature:_____Date:_____

Patient's Name:_____
Insurance Information:

Carrier:_____ I.D.#_____

Address:_____ Group #_____

City:_____ST____Zip_____ Phone_____

Appointments:

To cancel your appointment, please call 415 385-7587. If you do not reach someone, you may leave a detailed message on our voice mail. If you would like to reschedule your appointment, please leave your name and phone number. We will return your call promptly.

Late Cancellations: A cancellation is considered to be late when the appointment is cancelled without a 24 hour advance notice.

No Show Policy: A "no-show", is a patient who misses an appointment without cancelling it. Failure to be present at the time of a scheduled appointment will be recorded as a "no-show". This includes arriving 15 minutes after your scheduled appointment.

The first time there is a "no-show", late cancellation, or cancellation without a reasonable excuse there will be no charge to the patient. A 2nd occurrence will result in a fee of $50.00 billed to the patient. A 3rdwill result in a fee of the visit and the patient may be discharged from the practice.