

**Douglas A. Ehrenberg, D.P.M.**  
52 Mohawk Avenue  
Corte Madera, California 94925  
(415) 385-7587  
[www.wellfeet.com](http://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 2<sup>nd</sup> occurrence will result in a fee of \$50.00 billed to the patient. A 3<sup>rd</sup> will result in a fee of the visit and the patient may be discharged from the practice.