Shane D. Rhodes, D.P.M., F.A.C.F.A.S. — Foot and Ankle Specialist

Please print all information legibly. Thank you.

Patient Name______________________________________ **Birth Date**__________ **Male**____ **Female**____
First M.I. Last

Home Address____
Street City State Zip

Phones: Home________________ **Cell**________________ **Work**________________

S.S. Number ________________ **Driver's License** ________________

Employer________________ **Occupation**________________

Employer's Address____
Street City State Zip

Name of Responsible Party________________ **Relationship to Patient**________________

Home Address____
Street City State Zip

Phones: Home________________ **Cell**________________ **Work**________________

S.S. Number ________________ **Driver's License** ________________

Employer________________ **Occupation**________________

Employer's Address____
Street City State Zip

Emergency Contact________________ **Relationship to Patient**________________

Address________________________________ **Phone**________________

Do you have a Primary Care Physician? **Yes**_____ **No**_____

Physician's Name ________________________________ **Phone**________________

How did you find us? **Doctor Referral** **Patient Referral** **Ins. Co.** **Yellow Pages** **Saw Our Sign** **Other**________________
(please circle one)

Referring Doctor/Patient Name ________________________________

Pharmacy Name________________________________ **Phone**________________

AUTHORIZATION AND RELEASE OF INFORMATION

I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to myself, or my child, during the period of such care, to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor, or doctor's group, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

________________________________ ________________
Signature of Patient, Responsible Party or Guardian **Date**

25078 Peachland Avenue, Suite B Newhall, CA 91321-2557 Office (661)799-3668 Fax (661)799-3331
1560 E. Chevy Chase Drive, Suite 330 Glendale, CA 91206-4140 Office (818)247-0523 Fax (818)247-2945