Dr. Vicki L. Stone DPM
Podiatric Physician
6274 SW Capitol Hwy
Portland OR 97239

PATIENT INFORMATION

Please print legibly.

Please present your insurance card(s) and photo ID for copying.
COPAY IS DUE ON DATE OF SERVICE

Today's Date:________________

Name:______________________________ ________________________ ________
Last First MI

Marital Status: (circle) S M D W Gender: M F Occupation:___________________

Social Security No. (required):______________________ Birthdate:____________

Home Address:____
Number & Street City State & Zip

Phone(s) ______________________/_______________________/________________
Home Work Cell

Ok to leave message? Y N Y N Y N

PRIMARY DOCTOR:_______________________________ DATE LAST SEEN:________

Primary Insurance:_______________________________ID#:____________________

Group Number:_________________ Subscriber:______________________________

____
Rel. to patient Subscriber's employer phone

How did you hear of our office?____

Explain foot problem:____
Is this work related?_______ Due to auto accident?_______ Claim #_____________
Workers Comp or Auto/PIP Carrier:____

I acknowledge that I am financially responsible for all charges. I authorize the release of any medical information necessary to process primary and secondary insurance claims and I request that payment of medical benefits be made directly to the provider. I consent to the release of any medical information for the purpose of coordinating care and communicating with my primary care physician/provider. I understand and agree that a fee may be charged for appointments cancelled with less than 24 hours notice, and collections fees may be added to my account in the event that my account is sent to collections.

Signature:____ Date:________________