

CATHERINE CHEUNG, D.P.M.
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Confidential Intake Form

(To safeguard your information, please do not e-mail this form to us)

Contact Information

LAST NAME	FIRST NAME (ANY INITIALS; NAME YOU GO BY)	MR. <input type="checkbox"/> MS. <input type="checkbox"/> MRS. <input type="checkbox"/> DR. <input type="checkbox"/> OTHER/NONE <input type="checkbox"/>
ADDRESS	HOME TELEPHONE	CELL
	WORK TELEPHONE	FAX
OCCUPATION	DATE OF BIRTH	AGE
EMPLOYER	EMPLOYER ADDRESS	
EMPLOYER TELEPHONE		
FULL NAME OF SPOUSE	SPOUSE'S EMPLOYER	
SPOUSE'S CONTACT TELEPHONE NUMBER	SPOUSE'S WORK NUMBER	
OTHER EMERGENCY CONTACT PERSON	OTHER EMERGENCY CONTACT PERSON'S NUMBER	

Referral Information

REFERRED BY	PRIMARY CARE DOCTOR
REFERRING DOCTOR'S ADDRESS	

Reason for Visit (and Related Information)

WHICH PART OF THE BODY DOES THIS CONCERN?		RIGHT SIDE <input type="checkbox"/>	LEFT SIDE <input type="checkbox"/>
IS THIS AN ILLNESS?	IS THIS AN INJURY?	HOW LONG HAVE YOU HAD THIS ISSUE? (DATE OF ONSET OR INJURY)	
IF THIS IS AN INJURY, IT HAPPENED . . .			
AT WORK <input type="checkbox"/>	AT HOME <input type="checkbox"/>	DURING A SPORTS ACTIVITY <input type="checkbox"/>	AS THE RESULT OF AN AUTOMOBILE ACCIDENT <input type="checkbox"/>
NAME(S) AND CONTACT INFORMATION OF ANY OTHER DOCTOR(S) YOU HAVE SEEN FOR THIS			
ARE ANY RELATED RECORDS AVAILABLE?		X-RAYS <input type="checkbox"/>	MRI <input type="checkbox"/>
		CT <input type="checkbox"/>	EMG <input type="checkbox"/>
PURPOSE OF APPOINTMENT		CONSULTATION ONLY <input type="checkbox"/>	CONSULTATION AND TREATMENT <input type="checkbox"/>
		SECOND OPINION <input type="checkbox"/>	

Insurance Information

—PLEASE PROVIDE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST—

NAME OF PRIMARY INSURANCE PROVIDER	ID NUMBER	
NAME OF SUBSCRIBER	GROUP NUMBER	EFFECTIVE DATE
YOUR RELATIONSHIP TO SUBSCRIBER	CONTACT TELEPHONE NUMBER FOR PRIMARY INSURANCE PROVIDER	
SUBSCRIBER'S SOCIAL SECURITY NUMBER	SUBSCRIBER'S DATE OF BIRTH	
NAME OF SECONDARY INSURANCE PROVIDER	ID NUMBER	
NAME OF SUBSCRIBER	GROUP NUMBER	EFFECTIVE DATE
YOUR RELATIONSHIP TO SUBSCRIBER	CONTACT TELEPHONE NUMBER FOR SECONDARY INSURANCE PROVIDER	
SUBSCRIBER'S SOCIAL SECURITY NUMBER	SUBSCRIBER'S DATE OF BIRTH	

I hereby assign medical and/or surgical payments—including major medical benefits to which I am entitled, private insurance, and proceeds from any other health plan—to Catherine Cheung, D.P.M., for services she provides. This assignment shall remain in effect until I submit a written revocation to her. I understand that I am financially responsible for all charges for the provided services, whether or not they are paid for by such insurance. I hereby authorize assignee to release any of the above information to secure payment. A copy of this assignment shall be as valid as the original.

Date: _____

Patient Acknowledgment: _____