

Neil H. Hecht, D.P.M
Diplomate, American Board of Podiatric Surgery
Diplomate, American Board of Podiatric Orthopedics

Patient Information

Patient Name: _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ Age: _____ Sex: _____ Marital Status: S M W D

(*Optional) Race: _____ Ethnicity: _____ Preferred language: _____

E-mail address: _____

Would you like to receive e-mail appointment reminders: Yes / No

Referred By: _____

Family Physician: _____ Phone: _____

Driver's License No.: _____ State: _____ Social Security #: _____

Occupation: _____ Employed By: _____

Work Address: _____ Work Phone: _____

Medical Insurance

Company: _____ ID#: _____ Group: _____

Patient's Relationship to Insured: Self Spouse Child Other Insured's Name: _____

How will you pay your bill for professional services today? Cash Check Credit
(This includes any unpaid deductibles, co-pays, non-covered services, sterile & other miscellaneous supplies)

In case of Emergency whom can we contact: _____

Emergency Contact Phone#: _____

Previous Podiatrist: _____

Most Recent foot/ankle x-rays? _____

I hereby give my permission to Dr. Hecht to administer treatment as may be deemed necessary in the diagnosis and treatment of my complaints. I hereby authorize Neil H. Hecht, D.P.M to furnish information to third-party/insurance carriers concerning this illness and I hereby assign to the doctor all payments for medical services rendered and all major medical benefits.

Signature: _____ Date: _____

Relationship if parent/guardian: _____