NANTICOKE FOOT & ANKLE
DEEPA DIARAM, DPM, LLC

916 Middleford Road, Seaford, DE, 19973

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New Patient Form

Patient Name: _____
First *M.I.* *Last* *Suffix*

Male | **Female** **Date Of Birth:** _____ **SSN:** _____

Primary Phone: ( ) Home ( ) Mobile ( ) Work (_____)_____-_____ | **E-mail Address** *(Kareo Engage Direct Messaging)*

Phone #2: ( ) Home ( ) Mobile ( ) Work (_____)_____-_____ | _____

Street Address: _____ **City, State, Zip:** _____

Preferred Pharmacy: _____ **City:** _____

Marital Status: _____ **Employment Status:** _____ **Student:** _____

How will your services be paid for? ( ) **INSURANCE** *(please complete below)* ( ) **SELF PAY / OUT OF POCKET** *(next section)*

Primary Insurance: _____ **Policy/ Member #:** _____

Group #: _____ **Relationship to Policy Holder:** _____

Insurance Holder Name & SSN (*if not self*): _____ **DOB:** _____

Secondary Insurance: _____ **Policy/ Member #:** _____

Group #: _____ **Relationship to Policy Holder:** _____

Insurance Holder Name &SSN (*if not self*): _____ **DOB:** _____

Are you under the age of 18? _____ **If *Yes*, Guardian's Name / DOB:** _____

Emergency Contact : _____ **Relationship:** _____

Phone #1: ( ) Home ( ) Mobile ( ) Work _____ **Phone #2:** ( ) Home ( ) Mobile ( ) Work _____

I verify that the above information is factual and true to the best of my knowledge. I authorize *Deepa Diaram, DPM, LLC* to employ orders and referrals as deemed necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and / or copay / deductible payment / self-pay payment is due at the time of service.

I authorize this office to apply benefits on my behalf for the covered services rendered. I Certify that the insurance information I have provided is factual and correct.

_____ X_____

Patient Name Patient Signature Date