
# Traveling Podiatry Care

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**HOW DID YOU HEAR ABOUT TPC?**

| DATE CALLED IN | PREFERRED PHARMACY | PHARMACY PHONE NUMBER |
|---|---|---|
| | | |

| PATIENT LAST NAME | FIRST | MI | BIRTHDATE | SEX | MARITAL STAT |
|---|---|---|---|---|---|
| | | | | | |

| HOME ADDRESS | APT # | CITY | ZIP CODE (*****-****) |
|---|---|---|---|
| | | | |

| PRIMARY PHONE # | SECONDARY PHONE # | ETHNICITY | RACE |
|---|---|---|---|
| | | | |

PREFERRED METHOD FOR SCHEDULING MOBILE/CELL # EMAIL (Required for Portal Access)

**TEXT** **EMAIL**

| CONTACT PERSON FOR APPOINTMENTS | RELATIONSHIP | HOME PHONE # | WORK OR CELL # |
|---|---|---|---|
| | | | |

| PRIMARY DOCTOR'S NAME | OFFICE # | FAX # | MOST RECENT VISIT DATE |
|---|---|---|---|
| | | | |

| EMERGENCY CONTACT | RELATIONSHIP | HOME PHONE # | WORK OR CELL # |
|---|---|---|---|
| | | | |

| PATIENT SOCIAL SECURITY # | PATIENT MEDICARE # | PATIENT MEDICAID # |
|---|---|---|
| | | |

| INSURANCE CARRIER & CONTACT # FOR PROVIDERS | INSURANCE GROUP # | INSURANCE ID # |
|---|---|---|
| | | |

CHRONIC or ACUTE HEALTH CONDITIONS/CONCERNS (Be sure to note if the patient is Diabetic or on Anticoagulants/Blood Thinners)

**OFFICE USE ONLY: MEDICARE VERIFICATION AND CONFIRMATION OF COVERAGE**

PART B EFFECTIVE DATE _____ HMO STATUS _____ DEDUCTIBLE MET _____

MEDICARE PRIMARY _____ DATE CONFIRMED _____ INITIALS _____

**OFFICE USE ONLY: OTHER INSURANCE VERIFICATION AND CONFIRMATION OF COVERAGE**

EFFECTIVE DATE _____ DEDUCTIBLE MET _____ DATE CONFIRMED _____

CO-PAY AMOUNT $ _____ COINSURANCE AMOUNT _____% INITIALS _____

**COMMENTS:**

INITIALS: