BEAUMONT FOOT SPECIALIST
Dr.James Mark Bruyn

☐ **New Patient** ☐ **Update**

Name _____ _____/_____/_____ _____
First Middle Last Date of Birth

SS# _____--_____--_____ Marital Status: S M W D Gender: M F

Address_____
Street City State Zip

Hm Phone (_____) _____ - _____ Cell (_____)_____ - _____ WK (_____) _____ - _____

Employer_____ Occupation_____ Yrs Employe

SPOUSE / Parent Name _____ Birth date _____/_____/___
Parent if Patient is a Minor

Address _____
Street City State Zip

Hm Phone (_____) _____ - _____ Cell (_____)_____ - _____ WK (_____) _____ - _____

#1 EMERGENCY CONTACT_____/_____ Day Phone (_____)_____-___
(Relationship)

#2 EMERGENCY CONTACT_____/_____ Day Phone (_____)_____-___
(Relationship)

Referral Source: ☐ Physicain ☐ Former/Current Patient ☐ Friend ☐ Internet Search
☐ Insurance Co. ☐ Employer ☐ Family Member ☐ Our Website ☐

Insurance Information

1_____
Primary Insurance Company Policyholder Policyholder SS# Policyholder DOB Relation

_____
Member ID # Group #

2_____
Secondary Insurance Company Member ID # Policyholder Policyholder SS# Policyho

_____
Member ID # Group #

Medicare Number _____ Are you working? Yes No

I hereby authorize the release of any medical information necessary to process my claims and hereby assign to the physician all payments for medical se rendered to my dependents or myself. I understand that it is as a courtesy that the doctor accepts my insurance for payment and that if for any reason the pay my bill that I am responsible.

The practice accepts personal checks . In the event that a check "bounces" (i.e.,insufficient funds exist to cover the check),a **NSF fee of $35** will be appli patients receive a reminder call for upcoming appointments. Failure to appear or call to cancel prior to an appointment (**no show**) will result in a **$25 fee** I have completed this form accurately,and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the informatic requested. By signing below, I acknowledge and agree to abide by this policy.

SIGNATURE of Patient or Responsible Party X _____ Date:_____

6025 Metropolitan Drive, Ste.290 Beaumont,Tx 77706 TEL 409.833.7465 FAX 409.833.7719

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Age

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Other

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to Patient

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older DOB

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