WELCOME TO BAY PODIATRY ASSOCIATES

OFFICE OF DR. ISAAC TABARI & DR. ARIS MANTZOUKAS

8607 21st AVE, BROOKLYN, NY 11214 TEL: 718-266-1986 FAX: 718-26-2203

PATIENT REGISTRATION

Patient Information

Patient Name: Last | First | M.I. | □ M □ F

By what name to you preferred to be addressed? | Single Married Widowed Other

Patient's Address:

City | State | Zip

Home Phone: | Work Phone: | Cell Phone: | E-mail address:

Social Security #: | Birthdate: | Age:

Employer / School | Occupation:

Emergency Contact: | Phone#:

Would you like to receive occasional foot heatlh information on E-mail? □ Yes □ No

Insurance

Name of insured (if other than self) | Insured's Birth Date:

Name of insured's employer: | Insured's work phone number:

Patient is: □ Subscriber □ Spouse □ Dependent

We are required to have a copy of your insurance card(s) on file in order to bill your insurance for you.

Insurance Company: | Member ID#: | Group #

L&I Injury

Date of Injury: | Type of Injury: □ Work □ Auto □ Other

Has a claim been filed? □ Yes □ No Claim#: | Where was claim filed?

Cause of injury:

Referral

Referred By:

☐ Friend (name):____________________ ☐ Doctor (name):________________________

☐ Family (name): ____________________ ☐ Web search ☐ Other: ________________

Primary Care Physician and Clinic Name | Phone #:

Signature

Release of Benefits Information :

I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctors office will bill my insurance as a courtesy and that I am responsible for all co-payments, deductibles and non-covered services. I authorize the release of information required to process my claims. (If not signed payment due at time of service)

ALL CO-PAYMENTS DUE ON DAY OF SERVICE.

Patient Signature:______________________________ Date:______________________________

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