

The Advanced Footcare Center  
David P. Rosenzweig, DPM, PC  
90 South Ridge Street  
Rye Brook, New York 10573  
Phone: 914-937-7077 Fax: 914-937-7677

**WELCOME TO OUR OFFICE:**

Patient's Name: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_ Sex: \_\_\_\_\_  
Address \_\_\_\_\_ Apt. #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_  
Referring by: Physician \_\_\_\_\_ Advertising ( ) Internet ( ) Website ( )  
Friend ( ) Insurance Company book ( )

**INSURANCE INFORMATION**

**Your Medical Insurance Co.:** \_\_\_\_\_

Social Security No. of Insured                      Group #                      Insured Name

**Date of Birth of Insured:** \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Other Insurance Co.:** \_\_\_\_\_

Social Security No. of Insured                      Group #                      Insured Name

**Date of Birth of Insured:** \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

**PATIENT'S OR GUARANTOR'S EMPLOYER**

Employer: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Address: \_\_\_\_\_

I request that payment of authorized Medicare or other insurance carrier benefits be made on my behalf to Dr. David P. Rosenzweig for any services furnished, and I authorized the release of medical information to insurance carriers for the purpose of processing claims. Furthermore, it is my understanding that, regardless of insurance coverage, payment for services rendered is my responsibility.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_