

Scarlett Kroencke, D.P.M., F.A.C.F.A.S.  
Podiatric Medicine & Foot Surgery  
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PATIENT INFORMATION: Referring Physician or PCP: \_\_\_\_\_  
Pharmacy: \_\_\_\_\_

Patient First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_ SSN: \_\_\_\_\_  
Marital Status: S M D W (circle one)

Parent Name (if patient is a minor): \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_ SSN: \_\_\_\_\_  
Marital Status: S M D W (circle one)

Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_  
May we leave a message? Yes No (circle one)  
Occupation (patient or parent's): \_\_\_\_\_ Employer: \_\_\_\_\_  
Address: \_\_\_\_\_

Next of Kin/Emergency Contact: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_

INSURANCE INFORMATION:

Primary Private or Group Insurance Name: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
SSN: \_\_\_\_\_  
Secondary Private or Group Insurance Name: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
SSN: \_\_\_\_\_  
Do you have county/state Medi-Cal? Yes No (circle one)

The above information is true to the best of my knowledge. I authorize Scarlett Kroencke, D.P.M. to render services deemed necessary and agree to pay for such services. I authorize my insurance benefits to be paid directly to Scarlett Kroencke, D.P.M.. I understand that I am financially responsible for any balance.

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

(parent must sign if patient is a minor)