Far West Podiatric Medical Group, Inc.

13624 Hawthorne Blvd., Suite 206 **(310)675-0900**
Hawthorne, CA 90250 **Fax (310)675-0904**
Podiatric Medicine and Surgery

Welcome to Our Office
Patient Information

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____ Zip_____ email: _____

Date of Birth: _____ Age: _____ Gender: M F

Preferred Language: _____

How Do You Prefer We Contact You? (please circle one) phone email mail

Driver's License:_____ Social Security:_____

Patient's Employer:_____ Business Phone:_____

Emergency Contact:_____ Phone:_____
Relationship:_____

Medical Insurance:
Company name:_____ Insured's name:_____

Certificate number:_____ Group Number:_____

How were you referred to our office? (please circle one)
doctor internet patient insurance book insurance website facebook other

Briefly describe your foot problem: _____

ingrown nail hammertoe heel pain bunion wart

I hereby give permission to Far West Podiatric Medical Group to administer treatment as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle condition.

I hereby authorize my insurance benefits to be paid directly to Far West Podiatric Medical Group, Karen L. Wrubel, DPM and/or Derick A. Ball, DPM, and I am financially responsible for all non-covered services. I authorize the physician to release to the insurance company any information required to process this claim.

_____ _____
Date Signature (Parent or Guardian if under 18)