REED GRAHAM, DPM, INC.
696 CANTON RD., SUITE 1
AKRON, OH 44312

DATE: _____ **EMAIL ADDRESS:** _____

PATIENT NAME _____
LAST FIRST MI

ADDRESS _____

CITY/STATE/ZIP _____

SOCIAL SECURITY # _____ - _____ - _____ BIRTH DATE _____ / _____ / _____ SEX (M/F) _____ MARITAL STATUS _____
MO DAY YEAR

HOME PHONE _____ CELL PHONE _____

PLACE EMPLOYMENT _____ PHONE # _____

PRIMARY CARE DOCTOR _____ PHONE _____

ARE YOU DIABETIC? YES _____ **NO** _____ **ANY ALLERGIES** _____

PHARMACY NAME _____ **PHONE #** _____

HAVE YOU EVER BEEN TO PAIN MANAGEMENT: YES OR NO IF YES, WHERE: _____

PRIMARY INSURANCE _____

INSURANCE ID# _____ GROUP # _____

SUBSCRIBER NAME _____ RELATIONSHIP _____

SOCIAL SECURITY # _____ / _____ / _____ BIRTH DATE _____ / _____ / _____

SECONDARY INSURANCE _____

INSURANCE ID# _____ GROUP # _____

SUBSCRIBER NAME _____ RELATIONSHIP _____

SOCIAL SECURITY # _____ / _____ / _____ BIRTH DATE _____ / _____ / _____

RESPONSIBLE PARTY _____ RELATIONSHIP _____

ADDRESS _____ PHONE # _____

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE RELEASE OF ANY INFORMATION ACQUIRED DURING MY EXAMINATION OR TREATMENT TO MY INSURANCE CARRIER

AUTHORIZATION TO PAY BENEFITS: I HEREBY AUTHORIZE PAYMENTS DIRECTLY TO REED GRAHAM, DPM, INC. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED

X _____

PATIENT SIGNATURE, IF MINOR PARENT OR GUARDIAN