Arleta Foot Care, Inc.
Abid Chaudhry, D.P.M., F.A.C.F.A.S.
9068 Woodman Ave.
Arleta, Ca 91331
(818) 892-3196

Date: Welcome to Our Office ID#_____

Patient Information

Patient I Name: _____ **DOB:** / /
Last *First* *M.I.*

Address: _____
Street Address *Apt/ Unit #* *City* *State* *Zip Code*

Marital Status: ☐ *Single* ☐ *Married* ☐ *Widow* ☐ *Separated* Driver License: _____

Phone Number: ( ) _____ Message Phone Number: ( ) _____

Social Security # : _____ Age: ☐ **Female** ☐ **Male**

Responsible Party Information

Person Responsible*:* ☐ *Self* ☐*Spouse* ☐*Parent*

I Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apt/ Unit #* *City* *State* *Zip Code*

Primary Phone: _____ Driver License: _____

Social Security:: _____ DOB: _____

Insurance Information

Insured Name: _____ Insured Name: _____

Insured D.O.B: _____ Insured D.O.B: _____

Primary: _____ **Secondary:** _____

ID #: _____ ID #: _____

Policy/Group #: _____ Policy/Group #: _____

Referred By: _____ Family Physician: _____

I hereby authorize Abid N. Chaudhry, D.P.M., to release any information requested by my insurance carrier regarding treatment of the undersigned or my dependant.
I authorize payment directly to Abid N. Chaudhry D.P.M.., of any insurance payments or benefits otherwise payable to me. THIS IS TO INCLUDE ANY MAJOR MEDICAL in addition to BASIC BENEFITS PAYABLE. I understand I am responsible for any fee NOT PAID BY MY INSURSACE BENEFITS.

Insured Signature: _____**Date:**_____

Insured Name: (Print)_____**) Dependant Name (If applicable:** _____