

MENDOZA PODIATRY  
Gina Mendoza DPM PC

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

Work# \_\_\_\_\_ Cell# \_\_\_\_\_ Home# \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Referring Physician \_\_\_\_\_

Employer Name & Phone# \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone# \_\_\_\_\_

Please indicate a phone number that we are able to leave a detailed or private message on if we are not able to reach you. \_\_\_\_\_

Please list anyone and their relation to you that we may release your medical information to.  
\_\_\_\_\_

**Please read and sign the following statements**

I give the office of Dr. Mendoza permission to bill my insurance company for services that Dr. Mendoza provides to me. I understand that I am financially responsible for all services rendered by Dr. Mendoza that my insurance company does not pay. I understand that my co-pay is due before services are rendered. I understand that there will be a \$30.00 charge for any returned checked written to Dr. Mendoza.

Signature: \_\_\_\_\_ Today's Date \_\_\_\_\_

The Notice of Privacy Practices is available to you at your request. We will be happy to provide a copy to you should you ask. Please sign below to acknowledge that you understand that this policy is available to you.

Signature: \_\_\_\_\_ Today's Date \_\_\_\_\_