



# William F. Herrmann D.P.M

## Patient Information

DATE: \_\_\_ / \_\_\_ / \_\_\_

234 East 17<sup>th</sup> Street, #104  
Costa Mesa, California 92627

24953 Paseo De Valencia, #24B  
Laguna Hills, California 92653

NAME: Last \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_

AGE: \_\_\_\_\_ SEX:  MALE  FEMALE DATE OF BIRTH: \_\_\_ / \_\_\_ / \_\_\_ S S # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

MARITAL STATUS:  Single  Married  Widowed PHYSICIAN: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

SPOUSES NAME: Last \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_

SPOUSES EMPLOYER: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

PARTY RESPONSIBLE FOR ACCOUNT: \_\_\_\_\_

ADDRESS ( if different ): \_\_\_\_\_

IN CASE OF EMERGENCY, NOTIFY: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

WHO REFERRED YOU TO DR. HERRMANN:  Friend: \_\_\_\_\_  Newspaper: \_\_\_\_\_

Doctor: \_\_\_\_\_ Address: \_\_\_\_\_  Other: \_\_\_\_\_

## Insurance Company Information

PRIMARY INSURANCE:  MEDICARE  HMO  PPO  OTHER

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_ GROUP NAME: \_\_\_\_\_

GROUP # \_\_\_\_\_ ID# \_\_\_\_\_ YEARLY DEDUCTIBLE(S) MET?  YES  NO

SECONDARY INSURANCE: NAME \_\_\_\_\_

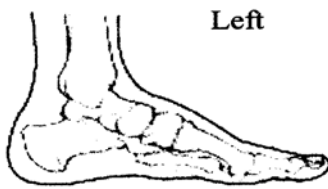
ADDRESS: \_\_\_\_\_ POLICY HOLDER: \_\_\_\_\_

GROUP NAME: \_\_\_\_\_ GROUP # \_\_\_\_\_

POLICY I.D. NUMBER: \_\_\_\_\_ YEARLY DEDUCTIBLE(S) MET?  YES  NO

## Medical Reason for Visit

- Ingrown Nail     Bunion     Injury     Heel Pain     Hammer Toes     Foot/Nail Care
- Skin Condition     Diabetic Foot Care     Orthotics     Other: \_\_\_\_\_



Left



Please use circles and arrows to indicate painful, injured or problem area(s)



Right

