Serenity Well-Being Clinic, P.A.

Comprehensive Podiatric Care

2701 Park Drive, Suite 6
Clearwater, FL 33763
727-631-1592

Original Date:
Dates Revised:

PATIENT INFORMATION

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F			**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Driver's License Number:		**Social Security Number:** - -	
Address:			
City:	**State:**		**Zip code:**
Home Phone: ( ) -	**Cell Phone:** ( ) -		**E-mail:**
Preferred method of communication	☐ Home Phone ☐ Cell Phone ☐ E-mail		
May we leave messages on answering services?	☐ Yes ☐ No		
May we discuss your health and treatment plan with anyone?	☐ Yes ☐ No	**If yes, whom?**	
Emergency Contact:	**Emergency Contact Phone:** ( ) -		
Favorite Music:			
Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

EMPLOYMENT

Employer:
Employer Phone:
Employer Address:
Occupation:

PRIMARY INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	**Birth date:** / /	**Address (if different):**	**Home phone no.:** ( ) -
Is this person a patient here? ❑ Yes ❑ No			
Occupation:	**Employer:**	**Employer address:**	**Employer phone no.:** ( ) -
Is this patient covered by insurance? ❑ Yes ❑ No			
Insurance name:		**Insurance address:**	

Subscriber's name:	**Subscriber's S.S. no.:** - -	**Birth date:** / /	**Policy no.:**	**Group no.:**
Have you met your yearly deductible? ❑ Yes ❑ No				

SECONDARY INSURANCE INFORMATION				
Person responsible for bill:	**Birth date:** / /	**Address (if different):**		**Home phone no.:** ( ) -
Is this person a patient here? ❑ Yes ❑ No				
Occupation:	**Employer:**	**Employer address:**		**Employer phone no.:** ( ) -
Is this patient covered by insurance? ❑ Yes ❑ No				
Insurance name:		**Insurance address:**		
Subscriber's name:	**Subscriber's S.S. no.:** - -	**Birth date:** / /	**Policy no.:**	**Group no.:**

Assignment and Release

I hereby authorize payment directly to Dr. Roboubi of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ **Date:** _____