William F. Herrmann D.P.M

Patient Information

DATE:____/____/____

☐ 881Dover Drive, Suite 150
Newport Beach, CA 92663

☐ 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:__________

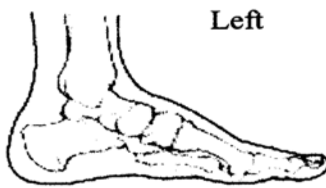
GROUP NAME:__________ GROUP #__________

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:__________



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