Allen Foot Doctors, part of Stride Healthcare

Neha Singh, DPM and Victor Schechter, DPM

Patient Name_____
(Last), (First) (Middle)

Address_____
(Street) (City) (State) (Zip)

Home/Cell Phone (_____)_____ Work Phone (_____)_____

Email _____

Date of Birth_____Age_____Marital status: M [ ] S [ ] D[ ] W[ ]

Social Security #_____Driver's License #_____

Employer_____Occupation_____

How did you hear of us? (Please be specific)_____

Which pharmacy do you utilize? Name _____

Pharmacy location: (cross streets) _____

City _____

IF YOU PLAN TO USE HEALTH INSURANCE TO PAY FOR OUR SERVICES PLEASE PRESENT YOUR ID CARD TO THE RECEPTIONIST.

_____
_____

*All patients are expected to pay their charges (co-payment in some cases) in full on the first visit. Arrangements must be made in advance, if this policy creates an undue hardship.

*There will be a $25.00 No-Show fee for patients who do not show up to their scheduled appointment, and payment will be required prior to subsequent appointments with the Doctors.

*I hereby give my permission to Dr. Schechter and Dr. Singh to examine and administer treatment, after consultation, and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition.

Signature of Patient, **Parent, Guardian, or Agent_____**

Date_____

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