

Drs. Sabet & Andrews  
31852 Coast Hwy., Suite 105  
Laguna Beach, CA 92651

## Welcome To Our Office

### Patient Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_  
Name You Go By \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_  
Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Employer \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Ext. \_\_\_\_\_  
Occupation \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Marital Status: M  S  W  D  Spouse's Name \_\_\_\_\_

### Referring Information

Who may we thank for referring you? \_\_\_\_\_  
Family Doctor \_\_\_\_\_ Previous Podiatrist \_\_\_\_\_  
What is your chief foot complaint? \_\_\_\_\_

### Financially Responsible Party (If different from patient)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Employer \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Ext. \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Eligibility Waiver

I state that I am eligible for benefits under \_\_\_\_\_ health plan. If the above is not true, I (or the person responsible for me) will be responsible for all charges related to services provided to me. In addition I understand that any services which are denied or are not part of my benefit package are my responsibility.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Email: \_\_\_\_\_