

Saddleback Valley Podiatry Group
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Laguna Hills, CA 92653
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David Sabet, DPM
Jan McCann, DPM
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WELCOME TO OUR OFFICE

Ms. Mrs. Mr. Miss: _____
Last First Initial

Home Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Cell number: _____ email address: _____

Social Security Number: _____ Driver's License: _____

Age: _____ Date of Birth: _____ Marital Status: S M W D

Employer: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Spouse, Parent or Guardian's Name: _____

Employer: _____ Business Phone: _____

Business Address: _____

Whom may we thank for referring you to this office?: _____

Family Doctor: _____ Last Seen: _____

Former Podiatrist: _____ Last Seen: _____

What problems are we seeing you for today?: _____

Insurance Company: _____ Subscriber's Name: _____

Group Number: _____ Policy Number: _____

I authorize payment from my insurance company to go directly to Saddleback Valley Podiatry Group, and the release of any medical or other information necessary to process this claim.

Signature: _____

I hereby give my permission to Saddleback Valley Podiatry Group to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot or ankle condition.

Date: _____ Patient Signature: _____
parent or guardian if patient is a minor

Relationship: _____