WEXLER FOOT CENTER
125 NEWTON SPARTA ROAD
NEWTON, NJ 07860
(973) 383-3115

PATIENT INFORMATION DATE _____________
(Confidential Information – Important for our Files and Your Health)

Patient Name _____________________________________ Date of Birth _________
Social Security Number _______________________________________Age _______
Home Address _______________________________ City ____________________
State ___________ Zip Code ____________ Spouse's Name __________________
Home Phone Number ____________________ Mobile Phone Number ____________
Email Address
____

Patient sex ☐ male ☐ female Patient is: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐Divorced
In case of emergency whom should we notify?
____
Phone Numbers(s) of person to call in emergency
____
Relation of person to call in Emergency
____
Whom may we thank for referring you to this office?
____
Relationship of person referring you to our office?
____

Employer Information: ☐ currently not employed ☐ On temporary leave ☐ **yes currently employed**
Patient employed by
____
Business Address
____
Patient Business Telephone Number(s)
____
Job Title/Description
____
Spouse employed by ____________________ Spouse Business Tel. # _____________
Spouse Business Address
____

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(973) 383-3115
FAX (973) 383-3201

Patient Name ______________________________________ **Date of Birth** ________________

Address of Patient ____

City, State Zip ____

1st Insurance Provider ____

Subscriber Name __________________________________ Date of Birth ________________

Employer ____

Insured's ID Number ____

Group Number ____

Insurance Phone Number ____

2nd Insurance Provider ____

Subscriber Name __________________________________ Date of Birth ________________

Employer ____

Insured's ID Number ____

Group Number ____

Insurance Phone Number ____

If additional Insurance information is needed please feel free to copy this form.

CRAIG WEXLER, D.P.M.
125 NEWTON SPARTA ROAD
NEWTON, NJ 07860
(973) 383-3115
(973) 383-3201

MEDICARE PATIENT AUTHORIZATION

Patient's Name: ___________________________

I REQUEST THAT PAYMENT OF AUTHORIZED Medicare benefits be made to me or on my behalf to Dr. Wexler for any services furnished by Dr. Wexler. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient's signature   Date

_________________________   ___________________________________