Eastern Shore Podiatry

Peter J. Cuesta, DPM

Last Name	First Name	Middle Initial

Mailing Address	City	State	Zip Code

Home Phone	Cell Phone	Work Phone

Preferred phone for contact/reminders	Sex ____ M ____ F	Marital Status

Race (U.S. Census categories - SELECT ONE)
____ White _____ African American or Black _____ American Indian or Alaskan Native ____ Hawaiian Native or Pacific Islander

____ Hispanic ____ Asian _____Other _____ Decline

Ethnicity (SELECT ONE) ____Hispanic or Latino _____ Not Hispanic or Latino _____Decline	Preferred Language ____ English _____ Spanish Other ____________________________
Social Security Number	Date of Birth

Primary Care Provider	Preferred Pharmacy	Pharmacy Location
Emergency Contact Name	Emergency Contact Relationship	Emergency Contact Phone Number

Primary Insurance Company			**Secondary Insurance Company**		
Name of Policy Holder			Name of Policy Holder		
Member Number	Group Number		Member Number	Group Number	
Address			Address		
City	State	Zip Code	City	State	Zip Code

Responsible Party/Guarantor-If patient is a minor (under 18), the parent or guardian

Last Name	First Name	Relationship to Patient	
Address	City	State	Zip Code
Birth Date	Social Security Number	Phone Number	

I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to Peter J. Cuesta, DPM, PA dba Eastern Shore Podiatry (ESP) all money to which I am entitled for medical expenses related to the services performed from time to time by ESP, but not to exceed my indebtedness to ESP. I authorize ESP to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to ESP. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I authorize Dr. Cuesta and/or other individuals he deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my podiatric/medical condition. This consent is valid for each visit I make to Eastern Shore Podiatry unless revoked by me orally or in writing.

I have reviewed a copy of Eastern Shore Podiatry's Privacy Practices Notice _______ (initial)

____ _________________________________

Patient/Responsible Party Signature Date