

West Coast Podiatry Center  
1611 53<sup>rd</sup> Ave W., Bradenton, FL 34207  
1961 Floyd Street, Suite C, Sarasota, FL 34239

**Dr. Stephen D. Lasday**  
**Dr. Robert M. Goecker**  
**Dr. Alissa Zdancewicz**

Patient Information

NAME: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Local Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

\*\*IS THIS A NURSING HOME OR ASSISTED LIVING FACILITY? YES NO

Ph No ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age ( ) \_\_\_ Male or \_\_\_ Female

Social Security No \_\_\_\_\_ Marital Status: Single Married Divorced Widow

Work Ph No: \_\_\_\_\_ Company Name: \_\_\_\_\_

PERMANENT RESIDENT OF FLORIDA? Yes No IF NO-PLEASE FILL IN OTHER ADDRESS BELOW:

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip Code \_\_\_\_\_

Ph No ( ) \_\_\_\_\_ E-Mail \_\_\_\_\_

\*\*\*IF YOUR INSURANCE IS THROUGH ANOTHER PERSON, PLEASE FILL IN BELOW

Relationship to patient: \_\_\_ Spouse \_\_\_ Parent \_\_\_ Legal Guardian \_\_\_ Other \_\_\_\_\_

NAME: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip Code \_\_\_\_\_

Ph No ( ) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security No: \_\_\_\_\_

Work Ph No: \_\_\_\_\_ Company Name: \_\_\_\_\_

I authorize the physicians at West Coast Podiatry to submit insurance claims on my behalf. I authorize and assign benefits, payable by my primary insurance company for my medical claims, to West Coast Podiatry Center. I request that this authorization also apply to any additional insurance benefits. I understand that I am responsible for my deductible, co-pay and any additional percentage required by my insurance company. I will also assume full responsibility for all incurred charges my insurance company has not paid within 60 days of the date that they received the claim. I realize that I am here for medical advice and possible treatment. I give permission to my treating doctor at West Coast Podiatry to perform those procedures that we have mutually agreed upon and to release my personal and/or medical information to other professional providers so that I may receive medical services from them. I understand that no guarantees or assurances have been made as to the results of any procedures or treatments.

SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*Originally Applied for Medicare in What State? \_\_\_\_\_

\*\*PLEASE TURN THIS FORM OVER