**Michael C. Edwards, DPM**
**Trenton K. Statler, DPM**

PODIATRY ASSOCIATES OF BEAUFORT

**Podiatric Medicine & Surgery**

Patient Name: _____ ◯Male ◯Female

Home Address: _____ City _____ State_____ Zip _____

Mailing Address: _____ City _____ State_____ Zip _____

Primary Phone Number: _____ Secondary Phone Number: _____

DOB: _____ Age: _____ SS#_____ Email Address: _____

Employer: _____ Occupation: _____ Work Ph# _____

Primary Care Physician: _____ May we send reports to him/her? ◯Yes ◯No

Pharmacy: _____ City: _____ Pharmacy Ph# _____

Do you have medical insurance? ◯Yes ◯No Primary Insurance: _____

Do you have secondary medical insurance? ◯Yes ◯No Secondary Insurance: _____

Policy holder's Name (if other than patient) _____ DOB: _____

Name of person responsible for paying this account: _____

Please briefly describe your foot problem: _____

**Patient or Authorized Person's Signature**

I authorize the release of any medical information necessary to process this claim and request payment of benefits either to myself or to Podiatry Associates when assignment is accepted.

Signature _____ Date _____

*"People get old – their teeth wear out and they get fillings and replacements; their eyes wear out and they get glasses of all kinds; their hearing wears out and they get hearing aids – but somehow, people never expect their feet to wear out. The feet are supposed to go on forever, and yet, they work harder and under worse conditions than most everything. Your podiatrist considers walking a privilege. He is dedicated to keeping you walking in comfort."*