Kara L. Montes, D.P.M.

(Please Print)

PATIENT INFORMATION (including minors)

PATIENT NAME Last First MI	**NICKNAME** ( )	**BIRTH DATE**	**SEX** ❑ Male ❑ Female	**Marital Status**(CIRCLE) M D S W
STREET ADDRESS	**MAILING ADDRESS (PO BOX)**		**HOME PHONE**	
CITY , STATE , ZIP	**SOCIAL SECURITY NUMBER**		**CELL PHONE**	
EMPLOYER	**EMPLOYER ADDRESS**	**BEST METHOD OF CONTACT(circle)** HOME CELL EMPLOYER OTHER	**EMPLOYER PHONE**	
PRIMARY LANGUAGE	**RACE (circle #)** (1) White (2) Black or African America (3) Asian (4) American Indian or Alaska Native (5) Native Hawaiian or Pacific Islander (6) Other	**ETHNICITY (circle #1 or #2)** (1)Hispanic or Latino (2)Non Hispanic or Latino	**EMAIL ADDRESS**	

RESPONSIBLE PARTY *(If different from above or patient is a minor)*

RESPONSIBLE PARTY NAME Last First MI	**BIRTH DATE** / /	**RELATIONSHIP TO PATIENT** ❑Parent ❑Guardian ❑Other ____________	**SEX** ❑Male ❑Female
STREET ADDRESS (if different from above)	**CITY, STATE, ZIP**		**HOME PHONE** ( )
SOCIAL SECURITY NUMBER	**EMPLOYER**	**EMPLOYER ADDRESS**	**WORK PHONE** ( )

PRIMARY INSURANCE			**SECONDARY INSURANCE**		
INSURANCE CARRIER NAME			**INSURANCE CARRIER NAME**		
ID #	**GROUP #**	**COPAY**	**ID #**	**GROUP #**	**COPAY**
INSURED'S NAME Last First MI			**INSURED'S NAME** Last First MI		
INSURED'S DATE OF BIRTH	**INSURED'S S.S. #**	**INSURED'S EMPLOYER**	**INSURED'S DATE OF BIRTH**	**INSURED'S S.S. #**	**INSURED'S EMPLOYER**
PATIENT-INSURED RELATIONSHIP ❑ Self ❑ Spouse ❑ Dependent ❑ Other ____________			**PATIENT-INSURED RELATIONSHIP** ❑ Self ❑ Spouse ❑ Dependent ❑ Other ____________		

IN CASE OF EMERGENCY

NAME OF FRIEND OR RELATIVE (not living with you or with different phone #)	**RELATIONSHIP TO PATIENT**	**CELL PHONE**	**OTHER PHONE**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for services not covered by my insurance company. I also authorize Kara L. Montes, D.P.M., P.C. and Copper Queen Community Hospital to release any information required to process my claims for payment. I permit a copy of this authorization to be used in place of the original.

______________________________ ______________

Patient/Guardian signature ***Date***