CAROLINA PODIATRY CENTER
DR. WILLIAM J. JOHNCOCK, DPM
Podiatric Medicine & Surgery

PLEASE PRINT

Last Name _____ First Name _____ Middle Initial _____
What would you prefer to be called? _____
Date of Birth _____ Age _____ S.S # _____
Mailing Address _____ City _____
State _____ Zip Code _____

Phone numbers (When you provide us with a wireless telephone number or land line number you are giving us your prior express consent to call that number.)
Home number _____ Cell number _____
Other number _____
Can message be left? Yes ____ No ____
Can we talk with other person/persons regarding your medical/financial information – list:
_____
Primary Language: _____
Race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White ***(circle one)***
Ethnicity: Hispanic or Latino / Not Hispanic or Latino
Single ____ Married ____ Divorced _____ Widowed ____
Employment ____ full time ____ part time ____ retired ____ none
Student ____ full time ____ part time ____ none
Occupation _____ Employer _____ phone number _____

Parent/Guardian (if minor) or Spouse's name _____
Occupation _____ Employer _____ phone number _____

Primary insurance _____ ID # _____ group # _____
Insured name (person who carries the insurance) _____ Date of Birth _____

Secondary insurance _____ ID # _____ group # _____
Insured name (person who carries the insurance) _____ Date of Birth _____

In case of emergency who should we contact? _____ phone # _____
Family doctor _____ date last seen _____
Who should we thank for referring you to our office? _____

I, the undersigned, assign directly to Dr. Johncock all my benefits, if any, otherwise payable to me for services rendered. I acknowledge that payment is due at the time of treatment, unless other arrangements are made, I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance. I understand that I am financially responsible for all charges regardless of insurance payment. I authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronic.

Date _____ Patient or Parent/Guardian Signature _____