CAROLINA PODIATRY CENTER
DR. WILLIAM J. JOHNCOCK, D.P.M.
Podiatric Medicine & Surgery

PLEASE PRINT

Last Name _____ First Name _____ Middle Initial _____
Date of Birth _____ Age _____ Gender M / F
Mailing Address_____ City _____
State _____ ZIP Code _____

Phone numbers (When you provide us with a wireless telephone number or landline number, you are giving us your consent to call that number.)
Home number _____ Cell number _____
Work number _____ Other number _____
Can message be left? Yes _____ No _____ E-Mail _____
Can we talk with other person/persons regarding your medical/financial information—list:
_____
Primary Language: _____
Race (*circle one*) American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White
Ethnicity: (*circle one*) 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 # _____

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

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 _____

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 _____