WILLIAM M. URBAS, D.P.M., P.C.

William M. Urbas, D.P.M.*
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Name:_____Social Security # _____

Male:_____ Female:_____ Date of Birth: _____Age: _____

Address: _____
/Street

_____
City State Zip

Employer's Name: _____

Email Address: _____

Home Phone: (____)_____Work: (____)_____Cell: (____)_____

Race: _____Language: _____Ethnicity: Non-Hisp / Hisp

If Minor, Name of Guardian:_____

Family Physician Name, Address & Phone #_____

_____

Pharmacy Name, Address & Phone #_____

_____

Who Referred You to Us? _____

Name of Insurance Company: _____

Insured's Name: _____Insured's Birthdate: _____

Policy or ID#: _____Group: _____

Insured's Place of Business: _____

Do You or Your Spouse Have any Other Insurance: Yes_____ No_____

If Yes, Please List: _____ ID# _____
Is Your Problem Related to An Accident ? Yes _____ No _____
If Yes, Auto_____Work _____ Other _____
Date of Accident: _____

"I request that payment of authorized Medicare and / or other insurance benefits be made to either myself or on my behalf to Dr. Urbas, for any services furnished to me by the doctor. I authorize any holder of medical information about me to be released to the Health Care Financing administration and / or other insurance companies and their agents, any information needed to determine these benefits payable for the related services"
I HEREBYGIVE THE DOCTOR PERMISSION TO EXAMINE AND TREAT MY CONDITION.

Name: _____ Date: _____