

**HARVEY R. DANCIGER, D.P.M., F.A.C.F.A.S.**  
**74-000 Country Club Drive, Suite A-2**  
**Palm Desert, CA 92260**

Dr. Harvey R. Danciger and staff wish to welcome you to our office. We will strive to provide you with the very best podiatric care. Please provide the following information to help us become better acquainted with you. Thank you.

PLEASE PRINT

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last Name) (First Name) (Middle)  
Local Address: \_\_\_\_\_ Effective Dates: \_\_\_\_\_ Out of Area Address \_\_\_\_\_ Effective Dates: \_\_\_\_\_

\_\_\_\_\_  
Street Number, Street Name, Apartment # \_\_\_\_\_  
Street Number, Street Name, Apartment # \_\_\_\_\_

\_\_\_\_\_  
City, State, Zip \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Phone # ( ) \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Cell Phone # ( ) \_\_\_\_\_

Marital Status: \_\_\_\_\_ Gender: M / F Social Security #: \_\_\_\_\_

Drivers License: State: \_\_\_\_\_ #: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employment Address: \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

NAME OF SPOUSE, PARENT OR GUARDIAN \_\_\_\_\_ Relationship: \_\_\_\_\_

Employed By: \_\_\_\_\_ Phone# \_\_\_\_\_ Occupation: \_\_\_\_\_

Employment Address: \_\_\_\_\_ SS#: \_\_\_\_\_

PARTY RESPONSIBLE FOR PAYMENT: \_\_\_\_\_

(If different than patient)

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

EMERGENCY CONTACT - NAME OF CLOSEST RELATIVE NOT LIVING WITH PATIENT:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone#: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

Street Number, Street Name, Apartment # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_ Phone#: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

Street Number, Street Name, Suite # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

PRIMARY INSURANCE:

Company: \_\_\_\_\_

Group#: \_\_\_\_\_ Policy/SSN# \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

SECONDARY INSURANCE:

Company: \_\_\_\_\_

Group#: \_\_\_\_\_ Policy/SSN#: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

*It is customary to pay for professional services when rendered unless prior arrangements have been made.*