SPORTS ARENA PODIATRY GROUP, INC **3405 KENYON ST. STE 502**
ANDREW J. FELFOLDI, DPM **SAN DIEGO, CA 92110**
JAMES J. FELFOLDI, D.P.M. **619/225-9601**

The following information will help us give you the best professional service possible and is necessary in order to keep accurate records. **PLEASE PRINT**

Patient Name _____Date _____

Address_____City/State_____Zip_____

Home Phone ( ) _____ Cell Phone ( ) _____

Sex _____ SS# _____-_____-_____ Driver License # _____

Birthdate _____ Age _____ Marital Status _____

Occupation _____ Employer _____

Work Phone ( ) _____ Work Address _____

Spouse Name _____ Phone ( ) _____

Emergency Contact _____ Phone ( ) _____

- Relationship to Patient _____

How were you referred to this office? _____

Reason for appointment _____

Primary Insurance _____

Name of Policyholder _____ Relationship to Patient _____

Policyholder Date of Birth:_____

Policy/ID # _____ Group # _____

Secondary Insurance _____

Name of Policyholder _____ Relationship to Patient _____

Policy/ID # _____ Group # _____

I hereby give my permission to Dr. Felfoldi to see me, discuss type of treatment necessary for my foot condition(s), administer treatment, and perform such procedures as may be deemed necessary in diagnosing and/or treating my foot condition(s).
I understand that I am responsible for all fees regardless of insurance coverage and that it is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that net 30 days, there will be a 1.5% late charge on all accounts 30 days or older, a minimum $10 will be charged for returned checks, and 60% of balance due will be added to accounts sent to collections. A $30 fee will be charged for appointments not cancelled or rescheduled within 24 hours of appointment time.

Signed _____
Patient or Guardian Signature