



Darryl E. Burns, DPM

Diplomate

American Board of Podiatric Surgery

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Name: \_\_\_\_\_ Social Security# \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ STATE \_\_\_\_\_ PHONE# \_\_\_\_\_

ZIP CODE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

Employer \_\_\_\_\_ YOUR WORK PHONE# \_\_\_\_\_

SPOUSE'S EMPLOYER \_\_\_\_\_ SPOUSE WORK # \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Is this problem related to: \_\_\_\_\_ EMPLOYMENT \_\_\_\_\_ ACCIDENT

FAMILY PHYSICIAN \_\_\_\_\_ DATE LAST SEEN \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

MEDICINES YOU AREN'T ABLE TO TAKE: \_\_\_\_\_

WHOM MAY WE CONTACT IN CASE OF EMERGENCY?

\_\_\_\_\_ PHONE # \_\_\_\_\_

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING INFORMATION REGARDING THE RESPONSIBLE PARTY:

NAME: \_\_\_\_\_ WORK PHONE # \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ SPOUSE NAME \_\_\_\_\_

PRIMARY INSURANCE \_\_\_\_\_ DO YOU HAVE A CO-PAY? \_\_\_\_\_

HAVE YOU MET YOUR DEDUCTIBLE? \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_

PLEASE HAND YOUR INSURANCE CARDS TO THE RECEPTIONIST SO WE MAY COPY  
I authorize use of this form on all my insurance submissions. I authorize release of information to all my insurance companies.  
I understand that I am responsible for my bill. I authorize my doctor to act as my agent in helping me obtain payment from  
insurance companies. I authorize payment direct to my doctor. I permit a copy of this authorization to be used in place of  
the original

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Darryl E. Burns, D.P.M.**

**SURGERY, MEDICINE & INJURY OF FOOT AND ANKLE**

**ACKNOWLEDGMENT OF RECEIPT  
OF  
NOTICE OF PRIVACY PRACTICES AND OFFICE POLICY**

**I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have (or had the opportunity to read if I so chose) and understand the Notice.**

**It is my responsibility to furnish Dr. Burns any Medical benefits that I have both primary and secondary.**

**If I am unable to provide the necessary information within 72 hours after my appointment it will then be my responsibility to pay for services in full and submit for reimbursement from my insurance company on my own.**

**OUR OFFICE DOES NOT TAKE MEDI-CAL INSURANCE**

**If you require any forms to be filled out, our fees are as follows:**

**Surgery patient's one form as a courtesy  
All other forms \$15.00 payable in advance**

**We no longer accept the responsibility of faxing or mailing forms, you will have to pick them up from our office upon completion.**

\_\_\_\_\_  
**Patient Name (print)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent or Authorized Representative**

\_\_\_\_\_  
**Signature**