Dr. SHERMAN NAGLER, D.P.M
1200 BINZ, STE. 1275B
HOUSTON, TX. 77004

Patient Name_____Date of Birth_____Age_____

Address_____City_____State_____Zip_____

Home Phone (__)_____Work Phone(__)_____

Cellular Phone (___)_____ Email Address___ _____

Marital Status: S M D W Male____ Female____

Spouse's Name_____ Spouse's Date of Birth_____

Patient SS#_____ Spouse's SS#_____

Relationship to Insured Self Spouse Child Other

Work Status: Full Time__, Part Time__, Retired__, Unknown__

Incase of Emergency: Name_____ Phone_____

Please list your **Primary Care Physician** and **date last seen**, also list who **referred** you:

Doctor_____ Last seen on:_____ **Referred by**:_____

Consent to Treat
I request and authorize the Physician and his staff to provide and to perform any procedures that they deem necessary.

_____ _____
Patient Signature Date

Payment Authorization
I hereby authorize payment of insurance benefits to Dr. Sherman Nagler and I authorize release of medical information about me to Doctors, Insurance, and it's agents.

_____ _____
Patient Signature Date

Laser Treatment Only
I hereby authorize treatment for PinPointe Foot Laser by Doctor/Staff, I am also aware this is a non-covered procedure.

Patient Signature_____ Date_____