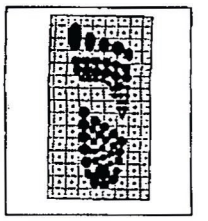
GREGORY J. TELES, D.P.M.
ALL SOUTH BAY FOOTCARE PODIATRY GROUP, INC.
23365 Hawthorne Blvd. Suite 101
Torrance, CA 90505
310-326-0202



PATIENT INFORMATION

EMAIL: _____

DATE _____ HOME PHONE (___) _____

PATIENT _____ DATE OF BIRTH _____
(Last, First, Middle) *(mmddyy)*

ADDRESS _____
(Street Address only) *(City/State)* *(Zip)*

RESPONSIBLE PARTY (parent, if minor) _____ DRIVERS LIC. _____
(Last, First, Middle)

SEX: [ ] Male [ ] Female AGE ___ STATUS: [ ] Married [ ] Single [ ] Divorced [ ] Other _____

PATIENT EMPLOYED BY _____
(parent, if minor)
BUSINESS ADDRESS _____
(City/State) *(Zip)*

OCCUPATION _____ BUSINESS PHONE (___) _____

SPOUSE'S NAME _____ DATE OF BIRTH _____ AGE _____
(of responsible party, last, first, middle) *(mmddyy)*
BUSINESS NAME & ADDRESS _____
(City/State) *(Zip)*

OCCUPATION _____ BUSINESS PHONE (___) _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ RELATIONSHIP _____

SOCIAL SECURITY # _____ SPOUSE'S SOCIAL SECURITY # _____

DO YOU HAVE MEDICAL INSURANCE? [ ] YES [ ] NO (if yes,)

NAME OF PRIMARY INSURANCE CARRIER _____

CONTRACT/GROUP # _____ SUBSCRIBER'S I.D. # _____

NAME OF SECONDARY INSURANCE CARRIER _____

CONTRACT/GROUP # _____ SUBSCRIBER'S I.D. # _____

IN THE EVENT OF AN EMERGENCY, who should we call? _____ PHONE (___) _____

PRIMARY CARE PHYSICIAN _____ PHONE (___) _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

PLEASE COMPLETE INFORMATION ON THE REVERSE, INCLUDING YOUR SIGNATURE.

You will be asked to return this registration along with your California Driver's License and Social Security Card. Please be sure to include your insurance I.D. card if applicable. Thank you for your cooperation.