FOOT & ANKLE SPECIALISTS, PLLC

PATIENT REGISTRATION FORM

Today's Date _____/______/______

PATIENT INFORMATION (PLEASE PRINT)

❑ Ms. ❑ Mrs. ❑ Mr.	Patient's Last Name	First	Middle

Date of Birth / /	Age	Sex ❑ M ❑ F	Social Security # - -	Marital Status (Circle One) Single / Mar / Sep / Div / Widow

Street Address	Home Phone No. ( ) -

Apartment #	City	State	ZIP Code

e-mail address: This will be used only if you specifically request (see other side of this form)

Occupation	Employer	Employer Phone No. ( ) -

How did you find us? (Check all that apply) ❑ Dr. ________ Referral? ❑ No ❑ Yes

❑ Insurance Plan ❑ Hospital or InstaCare ❑ Close to Home/Work ❑ Yellow Pages

❑ Internet ❑ Family ❑ Friend ❑ Other: ________

INSURANCE INFORMATION (PLEASE GIVE YOUR CARD TO THE RECEPTIONIST)

Is the patient covered by insurance? ❑ Yes ❑ No *_**Please identify the responsible party in the box below**_

Primary Insurance:	Policy Holder's Name:	
Policy #:	Group #	Co-Payment $
Patient's Relationship to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other:		

Secondary Insurance:	Policy Holder's Name:	Policy #	Group #

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Name of Responsible Party:	Date of Birth / /	Home Phone # ( ) -	
Street Address	City	State	Zip Code

IN CASE OF EMERGENCY

Name of Closest Relative or Friend (NOT living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Foot & Ankle Specialists, PLLC and/or my insurance company to release any information required to process my claims. I understand the all information provided will be kept strictly confidential unless otherwise authorized.

X ____

PATIENT, PARENT OR GUARDIAN SIGNATURE DATE