

**ADVANCED FOOT & ANKLE CENTER**

Physician Name: \_\_\_\_\_ Department Location: \_\_\_\_\_

**PATIENT REGISTRATION FORM**

**PATIENT INFORMATION**

Patient's Last Name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone: ( )		
City/State/Zip Code:				Cell phone: ( )		Work phone: ( )	
Email address:		Emergency contact name:		Emergency phone:		Emergency contact relation:	
Occupation:		Employer:			Employer phone no.: ( )		
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			

**GUARDIAN INFORMATION (IF PATIENT IS A MINOR)**

Name of Parent / Guardian:		Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
Address: Street / City / State / Zip Code: _____ (IF SAME AS PATIENT – CHECK HERE <input type="checkbox"/> )				

**GUARANTOR INFORMATION**

Guarantor responsible for bill:	Birth date: / /	SSN:	Guarantor phone no.: ( )
Relationship of Guarantor:	Guarantor address : (IF SAME AS PATIENT – CHECK HERE <input type="checkbox"/> )		Guarantor Employer: ( )

**1<sup>ST</sup> INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)**

Name of primary insurance (if applicable):		Insurance Address:		Insurance Phone: ( )	Type of Insurance: <input type="checkbox"/> Medicare <input type="checkbox"/> Private
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	IS THIS A WORK RELATED INJURY? _____

**2<sup>ND</sup> INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)**

Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

**DISCLOSURES / AUTHORIZATIONS**

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:** I hereby authorized payment directly to the Physician for any amount due to me for professional services, including major medical, under this claim. The authorization is to remain in effect until revoked by me in writing. I further authorize you to notify directly to the Physician of any rejections of this claim. I understand that regardless of my insurance status, I am ultimately financially responsible for all charges on any professional services rendered.

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize the Physician to release any information necessary to process claims and collect payment for services rendered.

**PATIENT / GUARANTOR SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_