Deanna Lynn Inlow, DPM

Physician Name:Dr. Deanna Inlow	*Department Location: Monterey*

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone: ( )

City/State/Zip Code:	Cell phone: ( )	Work phone: ( )

Email address: Occupation:	Emergency contact name: Employer:	Emergency phone:	Emergency contact relation:

Preferred Language: Circle one English Spanish Other:	Ethnicity: Circle one White Hispanic American Indian or Alaska Black or African American Native Hawaiian or Pacific Other	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ 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 ❑)

GUARANTOR INFORMATION

Guarantor responsible for bill:	Birth date: / /	SSN:	Guarantor phone no: ( )

Relationship of Guarantor:	Guarantor address : (IF SAME AS PATIENT – CHECK HERE ❑)	Guarantor Employer: ( )

1ST INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)

Name of primary insurance (if applicable):	Insurance Address:	Insurance Phone: ( )	Type of Insurance: ❑ Medicare ❑ Private

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	IS THIS A WORK RELATED INJURY? _____

2ND 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:	❑ Self	❑ Spouse	❑ Child	❑ Other	DOB:

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:**