Podiatric Registration and History

Last Name______________________ **First**____________________ **M.I**_______

Address_____________________________ City_____________ State______ Zip____________

Patient Phone Numbers & Information

E-Mail__________________ Home_____________ Work_______________ Cell______________

Birth date__________ Age: _______ Ethnicity: _________ Sex: M F

Patient SS#____________ Medical Doctor: ____________ who may we thank for referring you? _____

Emergency Contact: Name: ______________________ Relationship: _____________

Home #_________________ Cell# _______________________

Employment & Spouse Information

Employer___________________

Spouse's/ (Parent's name if Minor) Name________________ Birthday__________

Occupation______________ Spouse's/ (Parent's if minor) Employer ___________

Insurance & Financial Responsibility

Who is responsible for this account? ______________________Relationship to Patient________________

Primary Insurance _______________________ Address______________________________

Subscriber Name__________________ ID#_____________________ Group #____________________

Is patient covered by additional insurance (secondary ins)?
Yes No Insurance Co.____________________ ID# _____________

Assignment and Release
I understand that the responsibility for podiatric medical services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. All emergency podiatric medical services, or podiatry services performed without prior financial arrangements, must be paid for, in cash at the time of service. I understand that the office will assist me in submitting the appropriate insurance forms. However, discrepancies in payment between the insurance carrier and the charges incurred are my responsibility. In the event of death, I (we) promise to pay legal interest on indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Signed: ____________________________________ **Date**_______________
(Financially Responsible Person)

Relationship to Patient: _________________________