

| Advanced Foot & Ankle Center | | New Patient Registration Form | |
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| Information To Become Part Of your Confidential Medical Record | | Print Legibly | Today's Date |
| Patient's First Name | Middle Name | Last Name | |
| Patient's Age: | Patient's Date of Birth: (Month-Day-Year) | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status (circle one): Single Married Divorced Separated Widowed |
| Patient's Phone # Home: () Work: () Cell: () Email: | | Patient's Social Security Number: | Spouse's Month-Day-Year Birthday: Social Sec #: Employer: |
| Patient's Address (Please no PO BOX. Include Apt., Route, House and/or Street #) Address: City, State Zip Code: | | Spouse's Name (Last, First, Middle) | |
| Patient's Mailing Address (If different than address listed above) Address: City, State Zip Code: | | How did you hear about us? | |
| Patient's Primary Care Physician: | | Primary Physician's Phone #: | |
| Address of Patient's Employer: Street Address: City, State Zip code: | | Health Insurance Company: Primary Insurance Holder's Name: | |
| Complete Next Shaded Block Only if Patient is a Minor | | | |
| Mother's Name: First Last Middle Initial | | Marital Status (circle one): Single Married Divorced Separated Widowed Mother's address: | |
| Mother's Phone #: Home: () Work: () Cell: Email: | Address of Mother's Employer: Street Address: City, State: Zip code: | Mother's Birthday: (Month-Day-Year) Soc. Security #: | |
| Father's Name: First Last Middle Initial | | Marital Status (circle one): Single Married Divorced Separated Widowed Father's Address: | |

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| Father's Phone #: Home: () Work: () Cell: Email: | Address of Father's Employer: Street Address: | Father's Birthday: (Month-Day-Year) |
| | City, State: | Soc. Security #: |
| | Zip code: | |
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**Name, address & Phone Number of Relative or Friend NOT living with you in case of an emergency:
(Information is REQUIRED by Doctor)**

Name:
Address:
City, State
Zip code:
Contact's Phone#:
Relationship to Patient:

Today I will be paying by: Cash Credit Card Check

Read the following Payment Policy CAREFULLY then SIGN and DATE below

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| <p>1) Authorization to Release Medical Information: I authorize release of medical information necessary to process this (these) insurance claim(s) and permit the following to be used in place of this original document for all federal, state, commercial, compensation, or liability insurance claims:</p> <ol style="list-style-type: none"> 1) A photocopy or other facsimile reproduction of this authorization, or 2) Use of a computer to indicate my signature is on file at the Clinic, and/or 3) Use of a computer to electronically transmit my claim for Processing. <p>2 Authorization to Assign Medical Benefits To Clinic: I certify that Information provided relative to injury, illness, and Insurance coverage is both true and correct. I will notify the Clinic of any changes to the information supplied. I authorize Payment of insurance benefits or proceeds from any liability claim Or legal/court settlement to be assigned to the physician of this Clinic to the extent that their charges are paid in full.</p> <p>3 Acknowledgement of Insurance Limitations: Most Insurance carriers require a written referral from a primary</p> | <p>Care physician in advance of Services (office visits, surgery, and diagnostic Tests – MRI). Patient's are responsible for: (1) Obtaining physician Referrals and (2) contacting their insurance carrier to Verify benefits in advance of service. Patient's are also responsible for non-covered services, deductibles, co-Insurance, and any penalties imposed by their insurance Company on our doctor for seeing patients out of Network. Copayments and deductibles are due at the Time of service.</p> <p>4 Acknowledgement of Payment Responsibility: Payment for medical services is between the Clinic (doctor) and the patient. Payment is due in full according to the terms of this Clinics financial policy. Therefore, I understand that this Clinic cannot accept Responsibility for collecting or negotiating settlement Any disputed, (1) health insurance claim (2) worker's Compensation claim (3) accidental injury/illness liability Claim, (4) claim where patient is/will be represented by An attorney, and/or (5) claim to be settled in a court of Law.</p> |
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| Signature of Patient or Authorized Representative: X _____ | Date: |
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