



PATIENT REGISTRATION

Patient's Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: Male /Female (circle)

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____ Social Security # _____

Employer Name _____ Occupation _____

Employer Address _____ Work Phone _____

EMERGENCY CONTACT (Not Living with Patient)

Name _____ Relationship to Patient _____

Contact number _____

INSURANCE

Primary Insurance _____ ID# _____ Group# _____

Policy Holder _____ Patient's Relationship to Policy Holder _____

Date of Birth of Policy Holder (if different from patient) _____

Secondary Insurance _____ ID# _____

Preferred Method of Verbal Communication (Please circle one)

Home phone Cell phone Work phone

May we leave a message? (Please circle one) Yes No

PHARMACY INFORMATION

Name _____ City _____ Cross streets _____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature _____ Date _____

I also give permission for Premier Foot Clinic to have access to my electronic medication history

Patient's Signature _____ Date _____

ASSIGNMENT AND RELEASE:

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Premier Foot Clinic, P.C, all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible **for all charges** whether or not paid by insurance. I hereby authorize the clinic to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ Responsible Party Signature
_____ Relationship

OFFICE POLICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive imply some financial responsibility on your part.

Please review our office Financial Policy and the Notice of Privacy Practices. Once reviewed please read below:

I agree that the above information is correct to the best of my knowledge, and that I have read and understand all of Premier Foot Clinic's patient privacy, billing procedures, and financial policies

Patient Signature: _____ Date: _____

OR Legal Guardian Signature: _____ Date: _____