

Family Foot and Ankle Centers Patient Registration Form

(Please print and present your insurance cards to the receptionist)

Patient's Name _____
First Last M.I.

Address _____ Apt # _____

City State Zip code

Phone: Home _____ Cell _____

Work _____ Email _____@_____

SS# ____-____-____ Date of Birth ____/____/____ Gender ___ Male ___ Female

Marital Status _____ How did you hear about us? _____

Primary Care Doctor _____
Name, Address & Phone Number

Responsible Party Name _____
First Last M.I.

Primary Insurance Information- Policyholder Name _____

Policy # _____ Group # _____ Date of Birth ____/____/____

SS# ____-____-____ Insurance Name _____

Insurance Address _____

Co-pay Amount \$ _____ Relationship to Holder ___Self ___Spouse ___Guardian

Secondary Insurance Information- Policyholder Name _____

Policy # _____ Group # _____ Date of Birth ____/____/____

SS# ____-____-____ Insurance Name _____

Insurance Address _____

Co-pay Amount \$ _____ Relationship to Holder ___Self ___Spouse ___Guardian

Preferred Pharmacy: _____
Name, Address & Phone Number is **REQUIRED!**

Emergency Contact _____ Phone _____ Relationship _____

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I understand and acknowledge that I am personally responsible for the services rendered at this facility. Family Foot and Ankle Centers will bill my insurance carrier as a courtesy. In the event of non-payment, I understand I will be responsible for any outstanding balances.

X _____ Date _____
Patient Signature or Guardian for the Minor Patient