

PATIENT REGISTRATION INFORMATION



Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____



Date of Birth _____ Age _____ Sex: M / F Marital Status: M S D W

Home Phone _____ Cell Phone _____ Social Security # _____



Spouse's Name _____ Social Security # _____

Parent/Guardian Name (for child) _____ Social Security # _____



Employer _____ Work Phone _____ Ext. _____

Emergency Contact _____ Relationship _____ Phone _____



Primary Care Physician _____ Diabetic Care Physician _____

How were you referred to our office (PLEASE SPECIFY) _____



PERSON TO RECEIVE BILLS OR RESPONSIBLE PARTY (Complete if different than above)

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____



Home Phone _____ Cell Phone _____ Work Phone _____ Ext. _____



Social Security # _____ Date of Birth _____ Sex: M / F Marital Status: M S D W

INSURANCE INFORMATION

Primary Ins. _____ Secondary Ins. _____



Policyholders' Name _____ Policyholders' Name _____

Policyholder's Employer _____ Policyholder's Employer _____



Relationship to Patient _____ Relationship to Patient _____

DOB _____ Sex: M/F SS# _____ DOB _____ Sex: M/F SS# _____



Policy # _____ Group _____ Policy # _____ Group _____

I UNDERSTAND IT IS MY RESPONSIBILITY TO SEE A PROVIDER WHO PARTICIPATES WITH MY INSURANCE AND I ACCEPT FULL FINANCIAL RESPONSIBLE FOR ANY CHARGES DENIED IF COMMONWEALTH FOOT & ANKLE IS NOT A PARTICIPATING PROVIDER. I authorize **Commonwealth Foot & Ankle Center** to release any and all information acquired in the course of my treatment to my insurance company and to all medical providers participating in my health care. I authorize payment of medical benefits directly to **Commonwealth Foot & Ankle Center** and accept full financial responsibility for all charges not paid by insurance.



Signature _____ Date _____

Patient / Parent / Guardian

WELCOME TO COMMONWEALTH FOOT & ANKLE CENTER

HOW WERE YOU REFERRED TO OUR OFFICE?

Date _____

Please Check:

Physician or Medical Group (SPECIFY NAME)

Insurance Provider Directory

Practice Patient

Family Member

Friend

Co-worker

Neighbor

Telephone Directory

Newspaper Advertisement

Television Advertisement

Radio Advertisement

Internet Search

Our Website

Building Sign

Office Use Only

S A D