

FOOT SPECIALISTS OF CEDAR PARK & GEORGETOWN

PATIENT REGISTRATION

Welcome to our office! We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. **Please fill in all blanks, if information does not apply, please write "N/A".**

Last Name	First Name	MI
Street Address		
City	State	Zip
Phone ()		
Your email address:		
Date of Birth	Sex () Female () Male	SSN#
Marital Status ()Single ()Married ()Other		
Student ()No ()Yes- ()Full time ()Part time		
Driver's License Number		Family Physician's Name
Emergency Contact		Emergency Phone ()

Employer Information

Referred to our office by: _____

Employer	Work Phone ()
Employer Address	

Insurance Information

Primary Insurance Co.	Insurance #
Group #	Insured's Date of Birth
Sex ()Female ()Male	
Insured	Insured's Address
Insured's Employer	Relationship of Patient to Insured
Do you have a Secondary Insurance? () No ()Yes, complete information below. ____Initials	
Secondary Insurance Co.	Insurance #
Group #	Insured's Date of Birth
Sex ()Female ()Male	
Insured	Insured's Address
Insured's Employer	Relationship of Patient to Insured

Responsible Party (Fill out only if other than patient)

Last Name	First Name	MI
Street Address		
City	State	Zip
Phone ()		
Date of Birth	Sex ()Female ()Male	SSN#
Relationship to patient	Employer	Work phone ()

Payment Policy:

All services rendered are the financial responsibility of the patient or the patient's parent or guardian. The patient is responsible for payment regardless of insurance coverage. Billing information will be provided to expedite patient reimbursement from private insurance carriers.

Authorization of payment:

I hereby authorize the provider of services to release information concerning my examination and/or treatment for insurance purposes and to receive direct payment for benefits payable to me from services rendered.

Signed: _____ Date: _____
 (Patient or patient's parent or guardian, if minor)