The Foot & Ankle Clinic, LLC.

Patient Registration, Part 1

Patient Name_____ [ ] Male [ ] Female Birth Date:_____

Address_____ City_____ State_____ Zip_____

Home Phone: (____)_____ Work Phone: (____)_____ Social Security# _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed Occupation:_____

Employer/School:_____ Address:_____

May we leave a message at your home or with residents? [ ] Yes [ ] No On your answering machine/voice mail? [ ] Yes [ ] No

E-Mail address_____ Can we communicate with you via the Internet? [ ]Yes [ ]No

Name Person we may talk to about your medical concerns:_____

Is this contact only for emergency purposes only? [ ] Yes [ ] No, they can be contacted regularly about my care

Relationship:_____ Phone:_____

For minors only: Child lives [ ] with both parents [ ] Mother [ ] Father [ ] Emancipated Minor [ ] Other

Parent/Guardian_____ Address (if different)_____

Date of Birth:_____ Home Phone: (____)_____ Work Phone: (____)_____

Responsible party for insurance and bills: [ ] Patient [ ] Spouse [ ] Parents [ ] Mother [ ] Father [ ] Other_____

Primary Insurance Company:_____ Name on Contract:_____

Contract No:_____ Group No:_____ D.O.B._____

Relationship to card holder: [ ] Self [ ] Spouse [ ] Dependent Card Copied: [ ] Yes [ ] No Co-payment; $_____

Secondary Insurance Company: _____ Name on Contract:_____

Contract No:_____ Group No:_____ D.O.B._____

Relationship to card holder: [ ] Self [ ] Spouse [ ] Dependent Card Copied: [ ] Yes [ ] No Co-payment; $_____

Employer:_____

Identification of other physicians/health care entities involved with my medical care whom I authorize ongoing release of information for continuity of care:

Primary Care Physician:_____ Phone: (____)_____

Address:_____ Zip:_____

Other Physician:_____ Phone: (____)_____

Address:_____ Zip:_____

Type of physician/health care provided:_____

SIGNATURE_____ DATE_____

Information reviewed:_____/06 _____/07 _____/08 _____/09 _____/10 _____/11 _____/12 _____/13 _____/14 _____/15