

Patient Registration Form

Patient Information (PLEASE complete all applicable spaces)

Full First Name: _____ MI: _____ Last Name: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Alternate/Billing Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Best time and place to reach you: _____ E-Mail Address: _____

Age: _____ Birth Date: _____ Gender: M/F Social Security #: _____ Marital Status: _____

Employer Name/Address: _____ or Student: Yes/No

Chief Complaint: _____ Occurrence Date: _____ Related to: Work: Yes/No Auto: Yes/No Accident: Yes/No

Full Name of Family Doctor: _____ Date last seen: _____ Phone: _____

Primary Insurance (IN ADDITION to a copy of the insurance card)

Insurance Name: _____ If necessary did you bring your referral: Yes/No/NA

Insurance Phone # for eligibility: _____ Claims address: _____

Policy/Member ID: _____ Group/Account #: _____

Primary Insured's Full Name: _____ Date of Birth: _____ Gender: M/F SS #: _____

Primary Insured's home address: _____

Employer's Name: _____ Phone: _____

Employer's Address: _____

Secondary Insurance (ONLY if patient has Medicare as a primary/secondary)

Insurance Name: _____ If necessary did you bring your referral: Yes/No/NA

Insurance Phone # for eligibility: _____ Claims address: _____

Policy/Member ID: _____ Group/Account #: _____

Primary Insured's Full Name: _____ Date of Birth: _____ Gender: M/F SS #: _____

Primary Insured's home address: _____

Employer's Name: _____ Phone: _____

Employer's Address: _____

Privacy Information

Can we leave messages at any of the above listed numbers? Home: Yes/No Work: Yes/No Cell: Yes/No

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Names of family/friends who can pick up your records and/ medical supplies: _____

Names of family/friends who have parents' authorization to bring in the Minor child when guardian is absent:

Consent

I certify that the above and attached 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 to the diagnosis and/or treatment of me or my child's condition. As a representative of myself or as a guardian, I give authorization for the above listed patient to receive medical and/or surgical care and treatment with any of the Doctors at Complete Foot and Ankle Care of North Texas.

Printed Patient's Name: _____ Representative's Signature: _____ Date: _____

Office Representative Signature: _____ Date: _____