

**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

Full Name of Family Doctor: \_\_\_\_\_ Date last seen: \_\_\_\_\_ Phone: \_\_\_\_\_

Name(s) of Other Family Members (in household) Seen in Office:  
\_\_\_\_\_

**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 we CAN talk to about your medical needs or who CAN pick up your records and/ medical supplies:  
\_\_\_\_\_

Names of family/friends who we may NEVER speak to about your medical needs:  
\_\_\_\_\_

**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.

**Who is the person responsible for payment on this account:** \_\_\_\_\_

Printed Patient's Name: \_\_\_\_\_ Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Office Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_