Elite Foot & Ankle Center

PATIENT REGISTRATION FORM

PATIENT INFORMATION

DATE: _____ HOME PHONE: _____

NAME: _____ SOC SEC NO: _____
LAST NAME FIRST NAME MIDDLE INITIAL

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SEX: □ M □ F DOB: _____ AGE: _____ □ SINGLE □ MARRIED □ WIDOWED □ DIVORCED

EMPLOYER NAME: _____ WORK PHONE: _____

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____
FIRST NAME LAST NAME *FIRST NAME LAST NAME*

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

RACE: _____ ETHNICITY: □ NON-HISPANIC □ HISPANIC

EMAIL ADDRESS: _____ PREFERRED LANGUAGE: _____

PRIMARY INSURANCE

INSURANCE COMPANY: _____ PHONE: _____

INSURANCE ADDRESS: _____

RESPONSIBLE PARTY: _____ RELATION TO PATIENT: _____

DOB: _____ SOC SEC NO: _____ PHONE: _____

GROUP NUMBER: _____ INSURANCE ID: _____

ADDITIONAL INSURANCE

INSURANCE COMPANY: _____ PHONE: _____

GROUP NUMBER: _____ INSURANCE ID: _____

I, THE UNDERSIGNED, CERTIFY THAT I (OR MY DEPENDENT) HAVE ACTIVE INSURANCE COVERAGE AS LISTED ABOVE AND ASSIGN ALL BENEFITS TO CHAD SIMMONS, DPM OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE CHAD SIMMONS, DPM TO RELEASE ALL INFORMATION, DEMOGRAPHIC AND/OR MEDICAL, NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS.

_____ _____/_____/_____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN/HEALTHCARE POWER OF ATTORNEY *DATE*