



# 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.

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