

WELCOME TO:

FEET FIRST, INC., P.C.
PATIENT REGISTRATION SHEET

PATIENT INFORMATION (PLEASE PRINT)

DATE _____
NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
E-MAIL _____
SOCIAL SECURITY # _____ AGE _____ MALE FEMALE
BIRTH DATE (MM/DD/YYYY) _____ MARRIED DIVORCED SINGLE MINOR
SEPARATED

PATIENT EMPLOYER/SCHOOL _____
EMPLOYER/SCHOOL ADDRESS _____
EMPLOYER/SCHOOL PHONE (_____) _____
SPOUSES' NAME _____
BIRTH DATE (MM/DD/YYYY) _____ S.S.# (IF
KNOWN) _____
WHOM MAY WE THANK FOR REFERRING YOU? _____

PHONE NUMBERS

HOME PHONE(_____) _____ CELLPHONE(_____) _____ BEST TIME _____
IN CASE OF EMERGENCY, WHO CAN WE CONTACT?
NAME _____ RELATIONSHIP _____
HOME PHONE(_____) _____ WORK
PHONE(_____) _____

INSURANCE

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ RELATIONSHIP _____
INSURANCE COMPANY #1 _____ #2 _____
#3 _____
POLICY #1 _____ #2 _____
#3 _____

I HEREBY STATE THAT TO THE BEST OF MY KNOWLEDGE ALL THE ABOVE INFORMATION IS TRUE AND CORRECT. BY SIGNING BELOW I AUTHORIZE MY INSURANCE PROVIDER TO SEND ALL PAYMENTS DIRECTLY TO FEET FIRST, INC. I AGREE THAT I AM RESPONSIBLE FOR ALL DEDUCTIBLES, CO-PAYMENTS AND NON-COVERED SERVICES. I AUTHORIZE COORDINATION OF BENEFITS OF ANY SECONDARY INSURANCE COVERAGE. I ALSO AGREE TO REPORT ANY INSURANCE CHANGES THAT DO OCCUR WITH EITHER MY PRIMARY OR SECONDARY INSURANCE.

PATIENT/RESPONSIBLE PARENT/GUARDIAN SIGNATURE

DATE