New Patient Registration

Demographic Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Social Security #: _____
Gender: _____Race: _____Ethnicity: _____Language: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____Ext: _____

Cell Phone: _____Are you able to receive texts? ___Yes ___No
Email: _____

Marital Status: ____Single ____Married ____Divorced ____ Widowed
Employment Status: ____F/T____P/T ____Unemployed ____Student ____Retired

Consent for Leaving Voice Mail for Patient

Home Phone:

- Detailed Message __Yes __No
- Call Back Number Only __Yes __No

Cell Phone:

- Detailed Message __Yes __No
- Call Back Number Only __Yes __No

Work Phone:

- Detailed Message __Yes __No
- Call Back Number Only __Yes __No

Emergency Contacts/Consent to Discuss Healthcare Information

Name: _____

Phone: _____

Relation: _____

Name: _____

Phone: _____

Relation: _____

Primary Care Provider/Specialty Provider

PCP Name: _____

City/State: _____

Phone Number: _____

If VA: Location? _____

Other Provider that oversees your care?
(EX: Endocrinologist for Diabetes)

Name: _____

Specialty: _____

Pharmacy Information

Pharmacy: _____

City/State: _____

Phone: _____

Mail Order Pharmacy if Necessary:
_____

Whom may we thank for referring you to our practice?

_____

Primary Insurance

Insurance Company: _____Group #: _____
Subscriber #: _____
Insured's Name: _____DOB: _____
Social Security #: _____ Relation to Patient: _____

Does Patient have Additional/Supplemental Insurance? ___Yes ___ No

Insurance Company: _____Group #: _____
Subscriber #: _____
Insured's Name: _____DOB: _____
Social Security #: _____ Relation to Patient: _____

By signing below, you agree to the following statements:

- ✓ I received a hard copy to read concerning Office Policy, Insurance Policy, and HIPAA Policy.
- ✓ I understand I may receive a paper copy at my request.
- ✓ I understand the appointment and no-show policy.
- ✓ I understand the payment of fees and insurance billing.
- ✓ I understand my HIPAA rights.
- ✓ I understand I authorize **Foot Specialist of Tri-County** to share my information as described in the policies.
- ✓ It is my responsibility to update the office of any change of information or insurance.

Your Insurance Card and Photo ID are required at time of your visit.

The information that I have provided above is correct to the best of my knowledge.

_____ _____

Signature of Patient/Guardian Date