

Appointment date: \_\_\_\_\_ Check-in time: \_\_\_\_\_ Appointment Time: \_\_\_\_\_

**Patient Information (Please Print)**

Patient's Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_  
Address: (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Sex: M [ ] F [ ]  
Marital Status: Single [ ] Married [ ] Widowed [ ] Divorced [ ] Legally Separated [ ] Significant Other [ ]  
Email Address: \_\_\_\_\_  
Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_  
Employed: Yes [ ] No [ ] Retired [ ] If Yes, Full Time [ ] Part Time [ ] Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Student: Yes [ ] No [ ] If Yes, Full Time [ ] Part Time [ ] Reason For Today's Visit \_\_\_\_\_  
Primary Care Doctor: \_\_\_\_\_ Clinic Name: \_\_\_\_\_ (Date of last visit) \_\_\_\_/\_\_\_\_/\_\_\_\_  
Primary Doctor's Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Referred By: (Doctor/Friend/Co-worker's name or Other Entity) \_\_\_\_\_

**Person Financially Responsible For This Account (This is the Person Who Signs The Billing And Credit Policy)**

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ Relation to Patient: Self [ ] Spouse [ ] Parent [ ] Other [ ] \_\_\_\_\_  
Address: (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_  
Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_  
Drivers License: (Number) \_\_\_\_\_ (State) \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer: (Name) \_\_\_\_\_ (Phone) ( \_\_\_\_\_ ) \_\_\_\_\_

**Insurance Information (Please Print)**

Workers Comp: Yes [ ] No [ ] State Insured [ ] or, Self Insured [ ] Motor Vehicle: Yes [ ] No [ ] Date Of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Treatment Authorized by: Claims Manager [ ] Other [ ] New Claim [ ] Re-open Claim [ ] Claim Number: \_\_\_\_\_  
Claims Manager: (Name) \_\_\_\_\_ (Phone) ( \_\_\_\_\_ ) \_\_\_\_\_

**Primary Insurance Company/ Subscriber Information (Please Print)**

Insurance Company Name \_\_\_\_\_ (Address) \_\_\_\_\_ (Phone) ( \_\_\_\_\_ ) \_\_\_\_\_  
Does this insurance require a referral: Yes [ ] No [ ] if Yes Authorization number \_\_\_\_\_  
Is this plan: Group [ ] Individual [ ] Self Insured [ ] Other [ ] \_\_\_\_\_ Effective Date of this plan: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Subscribers Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation to Patient: Self [ ] Spouse [ ] Parent [ ] Other [ ] \_\_\_\_\_  
ID/Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Subscriber Employer: \_\_\_\_\_ Phone( \_\_\_\_\_ ) \_\_\_\_\_

**Secondary Insurance Company/Subscriber Information (Please Print)**

Insurance Company Name \_\_\_\_\_ (Address) \_\_\_\_\_ (Phone) ( \_\_\_\_\_ ) \_\_\_\_\_  
Does this insurance require a referral: Yes [ ] No [ ] if Yes Authorization number \_\_\_\_\_  
Is this plan: Group [ ] Individual [ ] Self Insured [ ] Other [ ] \_\_\_\_\_ Effective Date of this plan: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Subscribers Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation to Patient: Self [ ] Spouse [ ] Parent [ ] Other [ ] \_\_\_\_\_  
ID/Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Subscriber Employer: \_\_\_\_\_ Phone( \_\_\_\_\_ ) \_\_\_\_\_

**Person to contact in case of emergency (Not living with you):**

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

**Private Insurance Authorization for Assignment of Benefits/Information Release:**

I understand that the above information must be *complete, correct, and current* in order for my services to be billed to my insurance. I, the undersigned, authorize payment of medical benefits, both private and Medicare, to the Ankle & Foot Clinic of Everett for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company, their agent, or HCFA information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

\_\_\_\_\_  
Patient Signature (Parent or Guardian Signature If Child Under 18 Years)

\_\_\_\_\_  
Date

**PATIENT REGISTRATION**