ARCHES FOOT AND ANKLE CLINIC
REGISTRATION FORM

PATIENT INFORMATION

Today's date:				Email address:	
Patient's last name:	First:		Middle:	Home Phone Number:	
Preferred method of receiving appointment reminders: ❑ text ❑email ❑phone call				Cell Phone Number::	
Birth date: / /	Age:	Sex: ❑M ❑F	Race:	Ethnicity: Are you Latino or Hispanic ❑Yes ❑No ❑Decline	
Street address:				Social Security no.:	❑Single ❑Married ❑Partnered ❑Separated ❑Divorced ❑Widowed
P.O. box:	City:		State:	ZIP Code:	
Occupation:	Employer:			Employer phone no.: ( )	

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Website ❑ Other

Other family members seen here:

Primary Care Physician:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance company:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Arches Foot and Ankle Clinic or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*