

## Arches Foot and Ankle Clinic

# REGISTRATION FORM

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| --- |
| PATIENT INFORMATION |
| Today’s date: | Email address:  |
| Patient’s last name:  | First: | Middle: | Phone Number:  |
| **Preferred method for reminders**: ❑ text ❑email ❑call  | **Preferred Method for Statements:** ❑ text ❑ Mail  |
| Birth date: / / | Age: | Sex: ❑ M ❑F ❑ other  | 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 by (please check one box): | ❑ Dr. |  | ❑ Insurance |  |
| ❑ Family | ❑ Friend | ❑ Close to home/work | ❑ Website | ❑ Other |  |
| **Family members seen here:**  |  |
| **Primary Care Physician:**  |  |
| INSURANCE INFORMATION |
| 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 |  |
| PRIMARY insurance company: |   |  |  |  |  |
| Subscriber’s name: | Date of Birth: | Social Security Number: | Policy / ID Number: | Group Number: | Co-payment: |
|  |  / / |   |  |  | $ |
| Patient’s relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |  |
| SECONDARY insurance company (if applicable): | Subscriber’s name: | Date of Birth: | Policy / ID Number: |
|  |  |  / / |  |
| Patient’s relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |  |
|  |
| IN CASE OF EMERGENCY |
| Name of local friend or relative: | Relationship to patient: | 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 |  |