

## 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 | | | | | | | | | | |  |