



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: <input type="checkbox"/> text <input type="checkbox"/> email <input type="checkbox"/> phone call				Cell Phone Number:::	
Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Race:	Ethnicity: Are you Latino or Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline	
Street address:			Social Security no.:	<input type="checkbox"/> Single	<input type="checkbox"/> Married <input type="checkbox"/> Partnered
				<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
P.O. box:		City:		State:	ZIP Code:
Occupation:		Employer:		Employer phone no.: ()	
Chose clinic because/Referred to clinic by (please check one box): <input type="checkbox"/> Dr. <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital					
<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work <input type="checkbox"/> Website <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:	Employer:	Employer address:	Employer phone no.: ()		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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