Advanced Footcare Group, P.C.
REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____ PCP_____

PATIENT INFORMATION

Patient's Last Name **First** **Middle**

❑ Mr. ❑ Miss ❑Mrs. ❑ Ms	Marital Status (**Circle One**) Single / Mar / Div / Sep / Wid	Birth Date / /	Sex ❑ M ❑ F

Address	Social Security #	Home Phone No. ( )

City	State	ZIP Code

Email:

Occupation	Employer	Business Phone No. ( )	Cell Phone No. ( )

Referred to Advanced Footcare Group, P.C. by: ❑Friend/Co-worker ❑Doctor Referral ❑Newspaper ❑Insurance Co.

❑ Relative ❑Internet ❑Yellow Pages ❑Google ❑Yelp ❑Angie's List ❑ Linkedin ❑Other

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

NAME OF PRIMARY INSURANCE:

Policyholder's name.	Policyholder's S.S. #	Birth Date / /	Group #	Policy #	Co-payment $

Patient's Relationship to Policyholder ❑ Self ❑ Spouse ❑ Child ❑Other

NAME OF SECONDARY INSURANCE Policyholder's Name	Group #	Policy #

Patient's Relationship to Policyholder ❑ Self ❑ Spouse ❑ Child ❑Other

Pharmacy Name **Pharmacy Address** **Pharmacy Phone Number**

Medical Doctor's Name/Address

Current foot complaint/symptoms

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Patient	Home Phone No. ( )	Work 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 Advanced Footcare Group or insurance company to release any information required to process my claims. I acknowledge that I was provided and read (or had the opportunity to read)and understood ***The Notice of Privacy Practice*** **I am aware that the following information is available for viewing upon request;**

Information regarding the providers of care in this organization
A copy of the Patient's Bill of Rights and Responsibilities
Information regarding the grievance process
Ownership of Practice
DNR Policy
JCAHO Information

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS TO ADVANCED FOOTCARE GROUP, P.C. **please sign below**

x _____ **DATE**_____

HIPPA AUTHORIZATION **x** _____

PATIENT/GUARDIAN SIGNATURE **x**_____

Edited 5/26/11 , 11/30/11