Warren Podiatry - Patient Registration Form

PATIENT NAME: LAST_____ FIRST_____ MI____

CURRENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____ SEX: M____ F____

WHICH PHONE NUMBER IS BEST TO CONTACT YOU? **(PLEASE CIRCLE)** HOME CELL WORK

HOME PHONE: _____ CELL: _____ WORK: _____

EMAIL ADDRESS: _____

MARITAL STATUS: MARRIED _____ SINGLE _____ DIVORCED _____ WIDOWED _____ MINOR _____

IF MINOR, PARENT/GUARDIAN'S NAME: _____RELATIONSHIP: _____

CIRCLE PLEASE:

RACE: ASIAN AFRICAN AMERICAN NATIVE HAWAIIAN WHITE UNKNOWN DECLINED

ETHNICITY: NOT HISPANIC OR LATINO HISPANIC/LATINO UNKNOWN DECLINED

PREFERRED LANGUAGE: ENGLISH SPANISH FRENCH HINDU ARABIC OTHER DECLINED

IS TODAY'S VISIT RELATED TO: AUTO ACCIDENT YES ____ NO____ WORK RELATED INJURY: YES____ NO____

HOW DID YOU HEAR ABOUT US: _____

ARE YOU CURRENTLY EMPLOYED: YES____ NO____ RETIRED____ DISABLED____ OTHER _____

EMPLOYER: _____ JOB DESCRIPTION: _____

EMERGENCY CONTACT: _____ RELATIONSHIP:_____

ADDRESS: _____ PHONE: _____

ARE YOU IN NEED OF COMMUNITY SERVICES (I.E. TRANSPORTATION, ETC)? YES _____ NO _____

INSURANCE SUBSCRIBER'S NAME: _____ DATE OF BIRTH: _____

I hearby give my permission to the doctors of Warren Podiatry to administer treatment and to perform such minor operative procedures as may be deemed necessary, including photographs in the diagnosis and/or treatment of my foot/ankle condition. I authorize the release of any medical information necessary to process any claims as required by my health plan and to pay Warren Podiatry. I understand that although every attempt is made by Warren Podiatry to verify my insurance prior to my visit, it is my responsibility to know my individual coverage. If you are a member of **BLUE CARE NETWORK, HAP, MEDICAID** or any other **referral based insurance group**, with or without prior authorization, services performed may not be covered or paid for by the insurance company. If Medicaid is secondary to any insurance other than Medicare, I agree to pay the deductibe/co-pay for the visits. All charges including deductibles, co-pays and any non-covered charges are the patient's responsibility from the date the services are rendered. **I UNDERSTAND THAT PAYMENT FOR SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED** unless payment arrangements have been approved in advance by our staff. I have received a Notice of Privacy Practices. I have read, understand and agree to the provisions of this waiver and will be valid for all dates of service.

_____ DATE: _____

SIGNATURE OF PATIENT OR PARENT / GUARDIAN IF MINOR