Patient Registration

Date: _____

First Name: _____ How did you hear about us?

_____

Last Name: _____ Marital Status:

Address: _____ Single Married Divorced Widowed Sep Other

City: _____ Employer Name: _____

State: _____ Zip: _____ Work Phone: _____

Date of Birth: _____ Full Part Self Not Employed Retired Other

SSN: _____ Gender: M F

Home Phone: _____ E-Mail: _____

Family Physician: Name: _____ Phone: _____

Do you have: Allergies Diabetes Circulation Problems Require premedication

Other Condtitions: _____

Insurance Information

Primary Insurance: _____ Is insurance in patient's name? Yes No

Group Number: _____ Contract Number: _____

Secondary Insurance _____ Is insurance in patient's name? Yes No

Group Number: _____ Contract Number: _____

Insured Persons Information (If insurance is in the name of someone other than you.)

Insured First Name: _____ Insured Place of Employment: _____

Insured Last Name: _____ Insured Work Phone: _____

Insured Date of Birth: _____ Insured SSN: _____

Insured Home Phone: _____ Insured Gender: M F

Relationship to you: Spouse Child Other

Ins. Verification: By: _____ ☐ Pre-D ☐ Deductible_____ ☐ Ortho ☐ OV

☐ Needs Referral ☐ $ Limit _____ ☐ Restrictions to Foot Care: _____