PATIENT REGISTRATION

Patient Name: _________________________________ SSN # or ODL#_________________________
Birth Date _____/_____/_____ Age: _____ ❑Male ❑Female Marital Status:____Spouse:___________
Address:____
City ___________________State______Zip___________Phone# ( )________________________
Employer:____Phone# ( )________________________
Name of Nearest Relative Not Living With You:____
Relationship:_______________________________________Phone# ( )________________________
How Did You Hear of Our Office?____

INSURANCE INFORMATION

Insurance:____
Insured's Name:_____________________________I.D. #____________________Group#____________
Additional Medical Coverage:____
Insured's Name:_____________________________I.D. #____________________Group#____________

I authorize payment of medical benefits for professional services rendered.

Signed____ Date:____________________________

MEDICAL INFORMATION

Family Doctor:____Phone# ( )____________________
Date of Last Visit_________________Address____
Please list all medications you take (Including Herbal, aspirin, non-prescription):____________________
____
____
____
Please list all medical conditions you have (ex: diabetes, high blood pressure):______________________
____
____
Allergies:____ Weight:________ Shoe Size:________
Please state your current foot problem:____

NOTICE FOR WAIVER OF LIABILITY

I______________________________ understand that my insurance company, ______________________ may require a Primary Care Physician referral and/or prior authorization from the insurance company for services rendered, or that my insurance company may not cover services that they feel are not "reasonable and necessary" or covered under my particular insurance coverage plan. Therefore, I understand that I will be held financially responsible for any and all charges incurred at the time of this visit. I also understand that if the insurance information is not correct and/or if I do not have my insurance card available at the time of service, I will be held financially responsible for any and all charges incurred.

Member's Signature____ Date _________________