

Registration Sheet

Please Print:

Name (Last, First, M.I.) _____

Street Address _____

City _____ State _____ ZIP _____ Email Address _____

Telephone(____) _____ work(____) _____ cell(____) _____

Date of Birth ____/____/____ Age _____ Social Security Number ____/____/____

Referred By _____ Employer _____

Business Address _____ City _____ State _____ Zip _____

Business Telephone (____) _____ Occupation _____

Emergency Contact _____ Telephone (____) _____

Relationship _____

Primary Care Physician _____

Address _____ City _____ State _____ ZIP _____

Marital Status: Single Married Divorced Widowed Sex: M F

Spouse _____ Date of Birth ____/____/____ SS# ____/____/____

Employer _____ Business Telephone (____) _____

Address _____

Primary Insurance _____ Policy Number _____ Group _____

Secondary Insurance _____ Policy Number _____ Group _____

What is your foot problem? _____

List any drug reactions or allergies _____

Please list medications you are taking _____

I _____ hereby authorize my insurance plan or its agents to pay the claim directly to the physicians for services rendered. I permit a copy of this authorization to be used in place of the original. I authorize release of pertinent information to all my insurance company (s). I understand that I ultimately responsible for my bill.

Signature of Patient: _____ Date: _____