Foot Care Solutions Patient Registration

PATIENT INFORMATION: **TODAY'S DATE: _____**
Full Legal Name: _____ DOB: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
May we leave a message on your voicemail/answering machine? _____
SS#: _____ Sex: _____ Marital Status: _____

Responsible Party/Guardian Information: (if other than patient)
Name: _____ Relation: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact Information:
Name: _____ Relation: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Referring Physician: _____
Address: _____
Office Phone: _____ Office Fax: _____

Primary Care Physician: _____
Address: _____
Office Phone: _____ Office Fax: _____

INSURANCE INFORMATION:
Primary Insurance Carrier: _____ Phone: _____
ID#: _____ Group#: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Name of Insured: _____ Relation: _____
SS# of Insured: _____ DOB of Insured: _____

Secondary Insurance Carrier: _____ Phone: _____
ID#: _____ Group#: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Name of Insured: _____ Relation: _____
SS# of Insured: _____ DOB of Insured: _____

It is the your responsibility to verify our participation with your insurance plan prior to your visit. For those patients required to pay a co-pay, payment is required at the time of the visit. We accept payments in the form of cash, check, and/or credit card. In the event that your check is returned to us unpaid you will be charged a $30 returned check fee.

I attest that the above information is correct and I understand that I am responsible for any charges not covered by my insurance plan including any applicable co-pays, deductibles, and co-insurance.

Patient/Responsible Party Signature: _____ Date: _____