



# Premier Foot & Ankle Surgeons

## PATIENT REGISTRATION

### PATIENT INFORMATION

PLEASE PRINT

FULL NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_ AGE \_\_\_  
LOCAL ADDRESS \_\_\_\_\_ APT/SP \_\_\_\_\_ *Circle One* **Male/Female** *Marital Status* **S M W**  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIPCODE \_\_\_\_\_ HOME TELEPHONE \_\_\_\_\_  
SOCIAL SECURITY NO. \_\_\_\_\_ DRIVER'S LICENSE NO. \_\_\_\_\_ STATE \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_ BUSINESS TELEPHONE \_\_\_\_\_  
NEAREST RELATIVE NOT LIVING WITH YOU \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIPCODE \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
FRIEND OR NEIGHBOR IN CASE OF EMERGENCY \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIPCODE \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
PCP \_\_\_\_\_ REFERRED BY \_\_\_\_\_ TELEPHONE \_\_\_\_\_

### RESPONSIBLE PARTY

FULL NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIPCODE \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ BUSINESS TELEPHONE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIPCODE \_\_\_\_\_

### MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER \_\_\_\_\_ HMO/PPO YES\_\_\_ CO PAYMENT \$ \_\_\_\_\_  
DOES YOUR INSURANCE REQUIRE PRECERTIFICATION FOR PROCEDURES? YES\_\_\_ NO\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIPCODE \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
GROUP NO. \_\_\_\_\_ ID OR POLICY NO. \_\_\_\_\_  
POLICY HOLDER \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_  
SECONDARY INSURANCE CARRIER \_\_\_\_\_  
DOES YOUR INSURANCE REQUIRE PRECERTIFICATION FOR PROCEDURES? YES\_\_\_ NO\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIPCODE \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
GROUP NO. \_\_\_\_\_ ID OR POLICY NO. \_\_\_\_\_  
POLICY HOLDER \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_

### AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS, ASSIGNMENT OF BENEFITS & PAYMENTS

"I hereby authorize Premier Foot and Ankle Surgeons, it's Management and Physicians to release any information provided and acquired in the course of my examination and treatment, to my insurance companies and primary physician's office. I further authorize the filing of claims directly to my insurance companies and that payments for services rendered be made directly to my physician. I also understand and agree to be fully responsible for all charges. All past due account carry 3% monthly interest charge and if collection is necessary a minimum \$50.00 collection fee and any attorney's fees that may incur in the process of collection

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_