Foot & Ankle Clinic, P.C. 1502 Pierce St. Sioux City, IA 51105

PATIENT REGRISTRATION FORM

Referring or Family Doctor ________________________ Preferred Pharmacy _________________________

If you are diabetic, who is your current physician managing diabetic care _____________________________

Patient Name ____ Male _______ Female _______

SS# ________-______-________ Drivers License # _________________________________

Mailing Address _____________________________ City ______________ State _____ Zip Code ________

Date of Birth ______/______/______ Marital Status: Single ___ Divorced ___ Married ___ Widowed ___

Home Phone (____) ____-______ Work Phone (____) ____-______ Cell Phone (____) ____-______

Email Address: ___________________________________ Place of Employment ______________________

Race: Caucasian (White) Native American Hispanic African American (Black) Asian Other ________________

Ethnicity: Hispanic or Latin Not Hispanic or Latin Refused to Report

Preferred Language: ________________

Emergency Contact ____ Phone (_____) ______-________

Please present Insurance Cards and Photo ID to front desk.

Insurance Primary ________________________________ Insurance ID # ____________________________

Primary Insured Name ___________________________________ Insured D.O.B. _____/_____/_______

Insured SS # _______-______-_______ Insured Place of Employment ______________________________

Insurance Secondary ______________________________ Insurance ID # ____________________________

Secondary Insured Name ________________________________ Insured D.O.B. _____/_____/_______

Insured SS # _______-______-_______ Insured Place of Employment _____________________________

FINANCIAL POLICIES

We are committed to providing you and your family with the best possible health care. If you have medical insurance, we will be happy to help you process your insurance claim. **Co-payments are due at the time of service** for those insurance plans with which the Foot & Ankle Clinic, P.C. participates. For other insurance plans with which we do not participate, we must emphasize that our relationship is with you, not your insurance company. Insurance companies determine usual and customary fees in whatever manner they choose. Therefore, we would expect the balance upon receipt of your statement. I authorize payment of medical benefits including but not limited to Medicare benefits, be made on my behalf to Foot & Ankle Clinic, P.C.. This is a direct assignment of my rights and benefits. A photocopy of this assignment shall be considered effective and valid as the original. This signature card shall remain valid for any future services furnished to me by Foot & Ankle Clinic, P.C.. I am responsible for all medical fees regardless of insurance coverage. I authorize the release of any medical information necessary to process a claim.

Date ________/________/________ Signature ____