NELSON FOOT & ANKLE CLINIC

PATIENT REGISTRATION FORM

Today's date:_____

To protect your identity and due to Federal Health Insurance Portability and Accountability Act (HIPAA), this form should be filled out in its entirety. Thank you.

PATIENT INFORMATION

FULL NAME:_____
FIRST MIDDLE LAST
ADDRESS:_____
CITY:_____ STATE: _____ ZIP: _____

DATE OF BIRTH:____/____/_____ GENDER ☐ MALE ☐ FEMALE

HOME PH # ( ) _____-_____ CELL PH # ( )_____-_____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER

RACE: _____ HEIGHT: _____ WEIGHT: _____
SHOE SIZE: _____
SMOKING STATUS: ☐ NEVER ☐ FORMER SMOKER ☐ CURRENT SMOKER

REASON FOR VISIT: _____
ALLERGIES: _____
LIST OF CURRENT MEDICATIONS (INCLUDE VITAMINS AND OVER THE COUNTER ITEMS):_____

PRIMARY CARE PHYSICAN:_____ PH # ( ) _____-_____
PREFERRED PHARMACY:_____
REFERRED BY:_____
EMPLOYER NAME:_____ OCCUPATION: _____
EMERGENCY CONTACT:_____ PH # ( )_____-_____

INSURANCE INFORMATION

PRIMARY INSURANCE POLICY

INS. CARRIER NAME:_____
INS. ID#_____ POLICY/GROUP#_____
PRIMARY INSURED NAME:_____
PRIMARY'S DOB:____/_____/_____ PRIMARY'S SOC SEC#_____
PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ CHILD ☐SPOUSE ☐ OTHER_____

SECONDARY INSURANCE POLICY

INS. CARRIER NAME:_____
INS. ID#_____ POLICY/GROUP#_____

I request that payment of Authorized Medicare, AHCCCS, and/or Commercial Insurance be made to Nelson Foot & Ankle Clinic for any service(s) rendered to me. I authorize Nelson Foot & Ankle Clinic to release my medical information as regulated under the Federal HIPAA privacy laws. I further understand that I am responsible to pay certain amounts due to the physician. These amounts may include annual deductibles, co-pays, co-insurance, charges denied as not covered by my insurance(s), and charges denied for services or items determined as not medically necessary. I certify that the above information I have provided is accurate to the best of my knowledge and any missing information will be provided within 72 hours of my visit in order for Nelson Foot & Ankle Clinic to bill my insurance(s) on my behalf.

Patient or Guarantor Signature Printed Name Date