Associates In Podiatry
Patient Registration

Patient Name				**Gender**	**Male _____ Female _____**
Birthdate		**Age**		**SS#**	
CURRENT ADDRESS					
Address		**City, State, Zip**			

COMMUNICATION					
Home Phone #		**Work Phone #**		**Extension**	
Cell Phone #		**SMS or Text?**	**Yes _____ No _____**		
Who may we leave a message with?	**Patient Only _____ Patient and/or Spouse _____ Anyone answering the phone _____**				
Email					

GOVERNMENT REQUIRED INFORMATION **Check One in EACH Section**			
Primary Language	□ English □ Spanish □ Other □ Other: _____		
Race	□ American Indian or Alaska Native □ Asian □ Black or African Amercian □ Native Hawaiian or other Pacific Islander □ White □ Other Race □ Decline to Answer	**Ethnicity**	□ Not hispanic or latino □ Hispanic or Latino □ Unknown □ Decline to Answer

Do you Smoke ?	Yes _____ No _____	**If yes, How Much?**	
Do you Drink Alcohol?	Yes _____ No _____	**If yes, How Much?**	
Do you use Recreational drugs?	Yes _____ No _____	**If yes, How Much?**	

INFORMATION			
Marital Status	M ___ S ___ W ___ D ___	**Employer**	
Occupation		**Employer Phone/Address**	

Pt. Height:	**Pt. Weight:**	**Flu Shot: Yes_____ No _____; If Yes, when?_____**
List all Allergies:		
List all Medications:		
List all Surgeries:		
List all hospitalizations:		

Who may we thank for referring you? _____

PRIMARY INSURANCE					
Name		**Group Name**			
ID #		**Group #**			
Address					
Phone					
Insured		**Relationship to patient**		**Date of Birth**	

SECONDARY INSURANCE					
Name		**Group Name**			
ID #		**Group #**			
Address					
Phone					
Insured		**Relationship to patient**		**Date of Birth**	

EMERGENCY CONTACT		
Name	**Relationship**	**Phone #**

Primary Care Physician		**Date last seen:**	
PCP Address		**PCP Phone:**	
Preferred Pharmacy		**Pharm. Phone:**	
Pharmacy Address			

Associates in Podiatry is authorized to release medical information regarding my health to the following people:	

I have read a copy of the Associates In Podiatry NOTICE OF PRIVACY PRACTICES in accordance with the new HIPAA regulations.

Physician's release and agreement: I hereby authorize payment directly to Associates In Podiatry of benefits due to me from my Insurance Company otherwise payable to me. I further authorize the release of any medical information required by my Insurance carrier(s). A copy of this authorization may be used in lieu of the original. I authorize the holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or it's intermediaries or carriers any information needed for this or a related Medicare claim. I request payment of medical insurance benefits either to myself or to the part who accepts assignment. I understand that I am financially responsible for charges not covered by this authorization. If I fail to pay any outstanding balances, I will also incur any charges associated with the collection of these fees.

I understand I will be responsible for any fees incurred because I did not provide accurate insurance information. This includes not getting authorizations when required.

Patient's Signature:_____ **Date:** _____

Patient Name (Print:)_____