

# Raleigh Foot and Ankle Center REGISTRATION FORM

PLEASE FILL IN ALL BLANKS BEFORE RETURNING TO FRONT DESK

Today's date:				Primary Care Doctor			
				Address:			
<b>PATIENT INFORMATION</b>							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> MD <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Home phone no: ( )	Cell phone no: ( )	Social Security No:		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:			City		State/Zip Code		
Occupation:		Employer:		Employer Phone No: ( )		Email Address	
Spouse Information: Last name		First name:		Spouse Employer:		Spouse Employer phone no.: ( )	
Chose Raleigh Foot & Ankle Center Because (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Internet	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:							

<b>INSURANCE INFORMATION</b>							
<b>If patient is a student or under 21 please give parent information.</b>							
Person responsible for bill:		Birth date: / /		Address (if different):		Home phone no.: ( )	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:		Employer:		Employer address:		Employer phone no.: ( )	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				<b>Please give your insurance card to the receptionist</b>			
Please indicate primary insurance		<input type="checkbox"/> Medicare		<input type="checkbox"/> Medicare Advantage		<input type="checkbox"/> Blue Cross Blue Shield	
<input type="checkbox"/> United Health Care		<input type="checkbox"/> Cigna Health Care					
<input type="checkbox"/> Aetna		<input type="checkbox"/> Well path		<input type="checkbox"/> Medcost		<input type="checkbox"/> Medicaid	
<input type="checkbox"/> Other							
Subscriber's name:		Subscriber's S.S. no.:		Birth date: / /		Subscriber's employer:	
Employer phone no.:		Employer phone no.:		Employer phone no.:		Co-payment: \$	
Patient's relationship to subscriber:		<input type="checkbox"/> Self		<input type="checkbox"/> Spouse		<input type="checkbox"/> Child <input type="checkbox"/> Other	
Name of secondary insurance (if applicable):		Subscriber's name:		Birth Date: / /			
Patient's relationship to subscriber:		<input type="checkbox"/> Self		<input type="checkbox"/> Spouse		<input type="checkbox"/> Child <input type="checkbox"/> Other	

<b>IN CASE OF EMERGENCY</b>							
Emergency Contact:				Relationship to patient:		Home phone no.: ( )	
						Work phone no.: ( )	
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Raleigh Foot and Ankle Center or insurance company to release any information required to process my claims.</p>							
_____ <i>Patient/Guardian signature</i>						_____ <i>Date</i>	

# Consent

I give Raleigh Foot & Ankle Center my consent to use or disclose my protected health information to carry out my treatment.

I have been informed that I may review Raleigh Foot & Ankle Center's Notice of Privacy Practices (for a more complete description of users and disclosures) before signing this consent.

I understand that Raleigh Foot & Ankle Center has the right to change their privacy practices and that I may obtain any revised notices at the practice.

Signature \_\_\_\_\_ Date: \_\_\_\_\_  
**Patient, parent, or legal guardian**

Please State in your own words what the problem is: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **CONSENT FOR TREATMENT (SIGNATURE REQUIRED)**

I give permission to the physicians for Raleigh Foot & Ankle Center to administer treatment for my condition. If patient is a minor or incapacitated, guardian will sign here to give permission to the physicians to administer treatment deemed necessary in the diagnosis and treatment of the patient's condition.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

## **PAYMENT IS REQUIRED AT THE TIME OF TREATMENT**

**Our office does not accept Workman's Compensation or Auto Claims**

For Children, the parent who brings the child to the office is responsible for payment unless arrangements are made prior to treatment.

*Thank you.*