

Westside Podiatry
PATIENT REGISTRATION FORM

This information is confidential

INSURANCE INFORMATION

PATIENT INFORMATION

Name _____

Address _____

City _____

State _____ Zip _____

Telephone (____) _____

E-mail: _____

Social Security # _____

Male Female

Single Married Widowed Divorced

American Indian or Alaska Native Asian White

Black or African American Native Hawaiian

Hispanic Latino Other

Date of Birth _____

Occupation _____

Employer _____

Address _____

Work Phone (____) _____ Ext _____

Cell Phone (____) _____

Spouse Information (If Applicable)

Name _____

Home Phone _____

Work Phone _____ Ext _____

Primary Physician _____

Referring Physician _____

Office Use Only EHS Pt.# _____

Primary- Ins. Co. Name _____

Policyholder Name _____

Self Spouse

Policyholders Date of Birth ____/____/____

Employer _____

Secondary- Ins. Co. Name _____

Policyholder Name _____

Policyholders Date of Birth ____/____/____

Self Spouse

PHARMACY INFORMATION

Pharmacy Name _____

Address _____

City _____ State _____

Phone _____

EMERGENCY CONTACT (If other than Spouse)

Name _____

Relationship: _____

Telephone(____) _____

Complete only if patient is under age 18

Name _____

Address _____

City _____

State _____ Zip _____

Telephone (____) _____

SS# _____ DOB _____

Occupation _____

Employer _____

Address _____

Work Phone(____) _____ Ext _____

Westside Podiatry
PATIENT REGISTRATION FORM

Is your treatment today due to:

.....a work related injury Yes No Injury Date _____

Do you have written authorization from your employer and comp carrier to be treated Yes No

.....a motor vehicle accident Yes No Accident Date _____

.....a an accident/ liability case Yes No Accident Date _____

Whom may we thank for sending you to our office?

- Doctor _____
- Patient _____
- Newspaper _____
- Other _____

- Verizon Yellow Pages
- The Yellow Book
- Insurance Provider List
- Passed by Location Health Fair

I hereby authorize the release of any medical information pertaining to my treatment or information necessary for processing insurance claims and payment of medical benefits to myself or the party who accepts assignments. This authorization will remain valid until revoked by me in writing. I understand that I am legally responsible for all charges whether or not reimbursed by my insurance company.

Signature X _____ **Date** _____

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf of **Westside Podiatry** for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT'S NAME (Please Print)		PROVIDER: Name, Address, and Zip	
		<p>Westside Podiatry 11307 FM 1960 W Houston, TX 77064</p>	
PATIENT'S SIGNATURE			
PATIENT'S MEDICARE NO.	DATE		