Welcome to University Foot & Ankle Center

REGISTRATION FORM

Section I: Patient Information Date_____

Name: _____ I Prefer to be called: _____
Address:_____City:_____State:_____Zip_____
Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____
The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone
Date of Birth:_____ Social Security Number:_____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Spouse or Parent's Name: _____ Employer_____
Person to contact in case of emergency_____ Phone_____
Email Address_____
Primary Care Physician (PCP): _____
Anyone you would like to list who we can talk to in your absence? _____
Whom may we thank for referring you? _____
How did you hear about us? ☐ Google ☐ Direct Mail ☐ Website ☐ Living Social ☐ Other _____
We can get your medicine history from your pharmacy. Is this ok? YES or NO

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:_____ Relationship to Patient: _____
Address:_____
City:_____ State:_____ Zip:_____ Phone: (____)_____
Employer_____ Work Phone (____)_____ SSN#_____

Section III Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

---------- DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

I understand and agree that I will be responsible for payment of any and all services rendered by University Foot and Ankle Center, Dr. Jeffrey D. Poole or Dr. Caroline Gannon, and authorize the release of any diagnosis or records of treatment to my insurance(s) to support any medical claims made. I also authorize my insurance(s), Medicare/Medigap, to make payment directly to University Foot and Ankle Center, Dr. Jeffrey Poole or Dr. Caroline Gannon for services rendered. I certify the above information is true and correct. Should my account be forwarded to an outside collection agency, I agree to pay all collection fees and/or attorney fees incurred.

Signature _____ Date _____