Patient Registration Form

Demographic Information

Last: _________________________________ First: ____________________________ MI: _______

Date of Birth: ______/______/______(mm/dd/yy) Sex: ______ Race: _____________________

Social Security #: __________/______/_________ Ethnicity: ______________________________

Address: ___________________________________ Line 2: ________________________________

City: _______________________________________State: _______________ Zip: _____________

How did you hear about our practice? ____

Contact Information

Home: (______) - _______ - _______ Work: (______) - _______ - _______ Ext: ______

Cell: (______) - _______ - _________ Email: ____

Emergency Contact Information

Last: _________________________________ First: ____________________________ MI: _______

Address: ___________________________________ Line 2: ________________________________

City: _______________________________________State: _______________ Zip: _____________

Home: (______) - _______ - _______ Cell: (______) - _______ - _______

Primary Care Physician

Name: ________________________________Name of Practice: ___________________________

Address: ____ Phone: (______) - _______ - _______

City: _______________________________________State: _______________ Zip: _____________

Pharmacy Name: _________________________________ Phone: (______) - _______ - _______

Insurance Information

Primary Insurance

Insurance Company: ____

Policy#: ___________________________________ Group#: ______________________________

Insured Last: ________________________________ First: ______________________ MI: _______

Date of Birth: ______/______/______Sex: ______ Social Security #: _______/_____/________

Address: ___________________________________ Line 2: ________________________________

City: _______________________________________State: ________________ Zip: _____________

Advanced Directives? ☐ Yes ☐ No Where is it filed? _____________________________

Additional Insurance

Insurance Company: ____

Policy#: ___________________________________ Group#: ______________________________

Insured Last: ________________________________ First: ______________________ MI: _______

Date of Birth: ______/______/______Sex: ______ Social Security #: _______/_____/________

Address: ___________________________________ Line 2: ________________________________

City: _______________________________________State: ________________ Zip: _____________

Employment Status

☐ Employed ☐ Unemployed ☐ Full time student ☐ Part time student ☐ Retired

Address: ___________________________________ Phone: (______) - _______ - _______

City: _______________________________________State: ________________ Zip: _____________

Driver's License #: ____________________________________ State Issued: _______________

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT

Patient Registration

Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by _________________________ in order to carry out treatment, payment or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make any change to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the practice.

I agree and consent to releasing information to me in the following manners:

	Please Initial
Via Mail	
☐ OK to mail to home address	___________
☐ OK to mail to work address	___________
Via Home Telephone	
☐ OK to leave detailed message	___________
☐ Leave call back number only	___________
Via Cellphone	
☐ OK to leave detailed message	___________
☐ Leave call back number only	___________
Via Work Telephone	
☐ OK to leave detailed message	___________
☐ Leave call back number only	___________
Via Fax	
☐ OK to fax to: (______) - ________ - __________	___________

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: ____ Date: _____/_____/_______

Privacy Policy

I have been given a privacy policy and privacy procedures for the office of Denville Foot and Ankle.

Date: _____/_____/_____

Signature of Insured / Guardian: ______________________________________

Print Name: ____