Stockdale Podiatry Group, Inc.

MEDICINE AND SURGERY OF THE FOOT AND ANKLE

REGISTRATION FORM

PATIENT'S NAME ____

ADDRESS _____________________________ CITY ___________________ STATE ________

ZIP ___________ PHONE( ) __________ SEX ______ DATE OF BIRTH ____/____/____

MARITAL STATUS (CIRCLE ONE) M S D O

SOCIAL SECURITY #______-______-______ DRIVERS LICENSE # ___________________

WHO REFERRED YOU TO OUR OFFICE?____

EMPLOYER_____________________________ OCCUPATION ___________________________

BUSINESS ADDRESS _____________________ ZIP ________ PHONE( ) ______- _______

SPOUSE'S NAME _______________________ DATE OF BIRTH ______________/____/____

EMPLOYER_______________________ OCCUPATION __________________________________

BUSINESS ADDRESS _____________________ ZIP ________ PHONE( ) ______- ______

SOCIAL SECURITY #______-______-______ DRIVER'S LICENSE # ___________________

IN CASE OF EMERGENCY, CONTACT___________________________ RELATION __________

ADDRESS______________________________ ZIP ________ PHONE( ) ______- _______

***** PLEASE PRESENT RECEPTIONIST WITH INSURANCE CARDS AND/OR CLAIM FORMS. *****

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED TO STOCKDALE PODIATRY GROUP,INC.

THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS AGREEMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES WHETHER OR NT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

PATIENT'S SIGNATURE____ DATE __________________