Stockdale Podiatry Group, Inc.

MEDICINE AND SURGERY OF THE FOOT AND ANKLE

CHILD REGISTRATION FORM

PATIENT'S NAME _____

ADDRESS _____ CITY _____ STATE _____

ZIP_____ SEX _____ DATE OF BIRTH _____ SOCIAL SECURITY #_____-_____-_____

HOME PHONE ( ) _____ CELL PHONE ( ) _____

WHO REFERRED YOU TO OUR OFFICE? _____

RESPONSIBLE PARTY _____ RELATION _____

ADDRESS _____ PHONE ( ) _____

FATHER'S NAME _____ DATE OF BIRTH _____

ADDRESS _____ PHONE ( ) _____

EMPLOYER _____ OCCUPATION _____

BUSINESS ADDRESS _____ PHONE ( ) _____

SOCIAL SECURITY #_____-_____-_____ DRIVER'S LICENSE # _____

MOTHER'S NAME _____ DATE OF BIRTH _____

ADDRESS _____ PHONE ( ) _____

EMPLOYER _____ OCCUPATION _____

BUSINESS ADDRESS _____ PHONE ( ) _____

SOCIAL SECURITY #_____-_____-_____ DRIVER'S LICENSE # _____

EMERGENCY CONTACT _____ RELATION _____

ADDRESS _____ PHONE ( ) _____

***** PLEASE PRESENT RECEPTIONIST WITH INSURANCE CARDS. *****

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 NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

PARENT / GAURDIAN'S SIGNATURE _____ DATE_____