

Stockdale Podiatry Group, Inc.

MEDICINE AND SURGERY OF THE FOOT AND ANKLE

REGISTRATION FORM

PATIENT'S NAME _____

ADDRESS _____ CITY _____ STATE _____

ZIP _____ SEX _____ DATE OF BIRTH _____ MARITAL STATUS M S D O

HOME PHONE () _____ CELL PHONE () _____

SOCIAL SECURITY # _____ - _____ - _____ DRIVERS LICENSE # _____

WHO REFERRED YOU TO OUR OFFICE? _____

EMPLOYER _____ OCCUPATION _____

BUSINESS ADDRESS _____ PHONE () _____

SPOUSE'S NAME _____ DATE OF BIRTH _____

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.

PATIENT'S SIGNATURE _____ DATE _____