



## Registration Form

(Please Print)

Today's date:

### PATIENT INFORMATION

<b>Last name:</b>		<b>First:</b>		<b>MI:</b>	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?			<b>Birth date:</b> / /	<b>Age:</b>
				Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
<b>Street address:</b>			<b>Social Security no.:</b> - -		<b>Home phone no.:</b> ( )
<b>City:</b>		<b>State:</b>	<b>ZIP Code:</b>		<b>Other phone no.:</b>
<b>Occupation:</b>			<b>Employer:</b>		
<b>Chose clinic because/Referred to clinic by:</b>			<input type="checkbox"/> Dr. <input type="checkbox"/> Internet <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital <input type="checkbox"/> Other _____		

### INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

<b>Person responsible for bill (if different from above):</b>	<b>Birth date:</b> / /	<b>Address (if different):</b>	<b>Home phone no.:</b> ( )
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No			

### IN CASE OF EMERGENCY

<b>Name of local friend or relative:</b>	<b>Relationship to patient:</b>	<b>Home phone no.:</b> ( )	<b>Work phone no.:</b> ( )
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize <b>Performance Foot and Ankle Specialists</b> or my insurance company to release any information required to process my claims.</p>			
_____ <i>Patient/Guardian signature</i>		_____ <i>Date</i>	