



## Registration Form

Today's date:				
PATIENT INFORMATION				
Last name:		First:	MI:	Nickname:
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		Birth date: / /	Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:		Social Security no.: - -		Home phone no.: ( )
City:		State:	ZIP Code:	Other phone no.:
Primary Care Physician/Provider		Employer:		
Chose clinic because/Referred to clinic by:		<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.)			
Subscriber (if different from above):	Birth date: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No			

IN CASE OF EMERGENCY			
Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Performance Foot and Ankle Specialists. 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>	