

FAMILY FOOT CLINIC REGISTRATION FORM

DATE: _____ FAMILY PHYSICIANS _____
Physician Phone #: _____

Patient's Name: _____ Birthdate: _____

Patient Social Security No. _____

Address _____

Tele# _____ Cell# _____

Work # _____ Email address _____

INSURANCE

Primary Insurance _____ Policy# _____
(if minor, policy holder info)

Insured's Name _____ DOB _____ SS# _____

Secondary Insurance _____ Policy# _____

Insured's Name _____ DOB _____ SS# _____

Authorization and Release

I authorize release of any information concerning myself (or my child) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance otherwise payable to me directly to the doctor. I will be responsible for any remaining balance that I owe to Family Foot Clinic, OR any cost of court and attorney fees.

X _____ Date _____
Signature of patient (or parent if minor)

(434)-447-3395

(434)-447-4979-Fax