North Texas Foot and Ankle Specialists, P.C.

Patient Registration Form

Completed forms should be submitted to our office 48 hours prior to your appointment. All forms should be faxed to our confidential fax at 940-382-8805.

Patient Information (PLEASE complete all applicable spaces)

Full First Name: _____ MI: _____ Last Name: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Best time:_____ (AM/PM) & place to reach you: Home/ Work/ Cell/ Email. E-Mail Address: _____

Age: _____ Birth Date: _____ Gender: M/F Social Security #: _____ Marital Status: _____

Employer Name/Address: _____ or Student: Yes/No

How did you primarily hear about us: Friend Referring Dr Internet Insurance Newspaper Magazine Phone Book

Chief Complaint: _____ Occurrence Date: _____ Related to: Work:*Yes/No Auto:*Yes/No Accident: *Yes/No

Full Name of Family Doctor: _____ Date last seen: _____ Phone:_____

Primary Insurance (IN ADDITION to a copy of the insurance card)

Insurance Name: _____ If necessary did you bring your referral: Yes/No/NA

Insurance Phone # for eligibility: _____ Claims address: _____

Policy/Member ID: _____ Group/Account #: _____

Primary Insured's Full Name: _____ Date of Birth: _____ Gender: M/F SS #: _____

Primary Insured's home address: _____

Employer's Name: _____ Phone: _____

Employer's Address: _____

Secondary Insurance (ONLY if patient has Medicare as a primary/secondary)

Insurance Name: _____ If necessary did you bring your referral: Yes/No/NA

Insurance Phone # for eligibility: _____ Claims address: _____

Policy/Member ID: _____ Group/Account #: _____

Primary Insured's Full Name: _____ Date of Birth: _____Gender: M/F SS #: _____

Primary Insured's home address: _____

Employer's Name: _____ Phone: _____

Employer's Address: _____

Privacy Information

Can we leave messages at any of the above listed numbers? Home: Yes/No Work: Yes/No Cell: Yes/No

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Names of family/friends who can pick up your records and/ medical supplies: _____

Names of family/friends who have parents' authorization to bring in the Minor child when guardian is absent:

_____

Consent

I certify that the above and attached information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary to the diagnosis and/or treatment of me or my child's condition. As a representative of myself or as a guardian, I give authorization for the above listed patient to receive medical and/or surgical care and treatment with any of the doctors at ***North Texas Foot and Ankle Specialists, P.C.*** *see office policy and procedures

Printed Patient's Name: _____ Representative's Signature: _____ Date: _____