Permian Basin Foot and Ankle
PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name___________________________________ MI _____

Address____

City______________________ State_______ Zip_________

Telephone (____)_________________________________

***E-mail**:____

☐o not have an email   Deny to provide email

Primary Physician___________________________________

Phone# ___________________________________

Referring Physician___________________________________

Phone#___________________________________

☐Male ☐ Female

☐ Single ☐ Married ☐ Widowed ☐ Divorced

☐American Indian or Alaska Native☐Asian ☐ White

☐Black or African American☐ Native Hawaiian

☐Hispanic Latino☐Veteran ☐ Other

SSN____

Date of Birth_____________________________________

Occupation ______________________________________

Employer ____

Check Preferred Method

☐ Work Phone (____)____________Ext_________

☐ Cell Phone (____)_________________________

Spouse Information (If Applicable)

Name ____

Telephone _______________________________________

***Do you have an advanced directive?**

☐Yes   No   Do not resuscitate

(A legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity)

INSURANCE INFORMATION

Primary- Ins. Co. Name______________________________

Policyholder Name__________________________________

☐ Self ☐ Spouse

Policyholders Date of Birth_____/______/______

Employer____

Secondary- Ins. Co. Name____________________________

Policyholder Name__________________________________

Policyholders Date of Birth_____/______/______

☐ Self ☐ Spouse

PHARMACY INFORMATION

Pharmacy Name_____________

Phone#: __________________Fax#:_________________

Address____

City________________________ State________________

Zip________________________

EMERGENCY CONTACT (If other than Spouse)

Name____

Relationship:______________________________________

Telephone (____)___________________________________

Guarantor Information: Complete if different from Patient

Name____

Address____

City____

State______________________ Zip___________________

Telephone (____)___________________________________

DOB______________

Employer____

Work Phone (____)____________________Ext_________

Is your treatment today due to:

...............a work related injury ☐ Yes ☐ No Injury Date_______________________________

Do you have written authorization from your employer and comp carrier to be treated ☐ Yes ☐ No

...............a motor vehicle accident ☐ Yes ☐ No Accident Date_____________________________

..............a an accident/ liability cas ☐ Yes ☐ No Accident Date_____________________________

Whom may we thank for sending you to our office?

☐ Doctor_______________________________________

☐ Patient_______________________________________

☐ Newspaper___________________________________

☐ Other____

☐ Verizon Yellow Pages

☐ The Yellow Book

☐ Insurance Provider List

☐ Passed by Location ☐ Health Fair

I hereby authorize the release of any medical information pertaining to my treatment or information necessary for processing insurance claims and payment of medical benefits to myself or the party who accepts assignments. This authorization will remain valid until revoked by me in writing. I understand that I am legally responsible for all charges whether or not reimbursed by my insurance company.

Signature X____ Date____________________________________

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf of **Permian Basin Foot and Ankle** for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

<table>
<tr><td colspan="2">PATIENT'S NAME (Please Print)</td><td>PROVIDER: Name, Address, and Zip</td></tr>
<tr><td colspan="2"></td><td rowspan="5">Permian Basin Foot and Ankle
420 E 6th Suite 104
Odessa TX 79761</td></tr>
<tr><td colspan="2">PATIENT'S SIGNATURE</td></tr>
<tr><td>PATIENT'S MEDICARE NO.</td><td>DATE</td></tr>
<tr><td></td><td></td></tr>
</table>