Ankle & Foot Associates, LLC

David P. Murphy, D.P.M., FACFAS Gregory J. Kramer, D.P.M., FACFAS Robson S. Spinola, D.P.M., FACFAS Eric G. Massa, D.P.M., FACFAS Andrew Woods, D.P.M. FACFAS
T. Brent Ray, D.P.M. Howard Gale, D.P.M., FASPS Nicloe E. Wilson, D.P.M. Todd Becker, D.P.M., FACFAS Nicholas B. Dodson, D.P.M., FABPM, FABLES
Erin E. Dodson, D.P.M. Brian A. Falon, D.P.M., FACFAS Christin Runkel, D.P.M. Thomas J. Legacki, D.P.M. Danielle R. McKenna, D.P.M., FACFAS Lee M. Hlad, D.P.M.

REGISTRATION FORM

(Please Print)

Primary Care Physician:	Date Last Seen: _____ Pharmacy _____ Today's Date _____					

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Widow ☐			
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F	
Street address:	Social Security #:	Home phone #: ( )	Cell Ph. #: ( )			
P.O. Box:	City:	State:	Zip Code:			
Occupation:	Employer:	Employer phone #: ( )				
Chose clinic because/referred to clinic by (Please check one box)						
☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other		
Other family members seen here:						
Physician Referral: No _____ Yes _____ Physician _____ Ph# _____						

INSURANCE INFORMATION

(Please give your insurance card and photo ID to the receptionist)

Person responsible for bill:	Birth date:	Address (If different)	Home phone no.: ( )			
Is the person a patient here? ☐ Yes ☐ No						
Occupation:	Employer:	Employer address:	Employer phone no: ( )			
Is the patient covered by insurance? ☐ Yes ☐ No						
Please indicate primary insurance	☐ BCBS	☐UHC	☐Principal	☐ Aetna	☐ 1st Health	
☐ Medicare	☐ Medicaid	☐ Supplement	☐ Worker's Compensation	Other:		
Subscriber's name:	Subscriber's S.S. no:	Birth date:	Group #:	Policy #:	Co-payment: $	
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other		
Name of secondary insurance (If applicable):	Subscriber's name:	Group no.:	Policy no.:			
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other		

Name of local friend or relative (not living at same address):	Relationship to patient	Home phone no.: ( )	Work phone no.: ( )
Patient/Guardian signature _____	Date _____		
Would you like for us to leave a message? If so, what number _____			