ADVANCED FOOT and ANKLE SURGEONS, LLC

REGISTRATION FORM

CHART#

GENERAL INFORMATION						
First Name		**Middle Name**		**Last Name**		
SSN	**Birth Date**	**Gender** ☐ Male ☐ Female		**Preferred Name**		
ADDRESS and PHONE						
Home Address				**Zip code**		
Home Phone	Area code	Number	**Work Phone**	Area code	Number	Extension
Cellular Phone	Area code	Number	**Preferred Phone** ☐ Home ☐ Work ☐ Cellular			
Preferred method of communication ☐ Phone ☐ Mail ☐ Email						
Mailing Address *(if different from home address)-*				**Zip code**		
Email Address						

OTHER			
How did you hear about us?	☐ Dr. ☐ Insurance ☐ Internet/Google ☐ Facebook ☐ Friend/Family ☐ Newspaper ☐ Billboard		
Race	**Ethnicity:** ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ Unreported/Refused		
Preferred Language ☐ English ☐ Spanish ☐ Other		**Do you need an interpreter?** ☐ Yes ☐ No	
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner			
Employment ☐ Full-Time ☐ Part Time ☐ Not Employed		**Employer**	

PRIMARY INSURANCE			
Insurance Plan Name			
Subscriber ID		Group Number	
Effective Date		Group Name	
Insured's Name		Date of Birth	
Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Partner		Social Security Number	

SECONDARY INSURANCE			
Insurance Plan Name			
Subscriber ID		Group Number	
Effective Date		Group Name	
Insured's Name		Date of Birth	
Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Partner		Social Security Number	

ASSIGNMENT OF BENEFITS

- I understand I am financially responsible for all charges and services provided to me, including the balance remaining after payment of potential insurance benefits. I authorize payment of medical insurance benefits to Advanced Ankle and Foot Surgeons, LLC for professional services rendered.
- I authorize the release of any information necessary to process this claim.
- I certify that all the above information is true and correct to the best of my knowledge. I give my permission to the Provider and/or medical staff to administer and perform such procedures deemed necessary in the diagnosis and/or treatment of my podiatric condition(s).

Signature of Patient / Legal Guardian/Representative	**Relationship**	**Date**