CORPUS CHRISTI PODIATRY

REGISTRATION FORM

Today's Date: PCP:

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status ☐ Sgl ☐ Mar ☐ Div ☐ Sep ☐ Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former Name)	Birth Date	Age	Sex ☐ M ☐ F

Street Address	City	State	ZIP Code	Social Security	Home Phone No. ( )

P.O. Box	City	State	ZIP Code

Occupation	Employer	Employer Phone No. ( )

Chose Clinic Because/Referred to Clinic by (Please check one box) ☐ Dr. _____ ☐ Insurance Plan ☐ Hospital

☐ Family ☐ Friend ☐ Close to Home/Work ☐ Yellow Pages ☐ Other _____

Other Family Members Seen Here _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date	Address (if different)	Home Phone No. ( )
Is this person a patient here?	☐ Yes ☐ No		

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐ (AETNA) ☐ (MEDICARE) ☐ (BC/BS) ☐ (HUMANA) ☐ (CIGNA)

☐ (PHYSICIANS HC) ☐ (Christus Spohn) ☐ (United HC) ☐ (Tricare) *(Please provide coupon)* ☐ Other _____

Subscriber's Name	Subscriber's Social Security #	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 #	Policy #

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [**Name of Practice**] or insurance company to release any information required to process my claims.

X _____

PATIENT/GUARDIAN SIGNATURE DATE