MADISON FOOT & ANKLE CARE, P.A.

Eric E. Barton, D.P.M.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

FULL LEGAL NAME:_____ PREFERRED NAME:_____

SEX: M ❑ F ❑ DATE OF BIRTH:____-____-____ S.S.#:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

CELL PHONE: (____)_____ HOME PHONE: (____)_____ WORK PHONE: (____)_____

EMPLOYER: _____

PRIMARY PHYSICIAN:_____ **WHO REFERRED YOU TO US?:**_____

PREFERRED PHARMACY: _____

IS PATIENT A STUDENT?:_____ **FULL TIME** ❑ **PART TIME** ❑

IF COLLEGE STUDENT, GIVE PERMANENT ADDRESS: _____

_____

MARITAL STATUS: SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED ❑ LEGAL. SEPARATED ❑

E-MAIL ADDRESS OF: PATIENT ❑ **PARENT** ❑ **OTHER (SPECIFY)** ❑ _____

_____

❖ **PERSON TO CONTACT IN CASE OF EMERGENCY:** _____

RELATIONSHIP TO PATIENT:_____**PHONE: (**_____**)**_____

RESPONSIBLE PARTY - PERSON WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT

PATIENT'S RELATIONSHIP TO RESP. PARTY: _____ DRIVERS LICENSE #:_____

RESP. PARTY'S NAME: _____S.S.#:_____DATE OF BIRTH:____-____-____

RESP. PARTY'S ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE: (____)_____ WORK PHONE: (____)_____ CELL PHONE: (____)_____

RESP. PARTY'S EMPLOYMENT STATUS: EMPLOYED FULL TIME ❑ EMPLOYED PART TIME ❑ RETIRED ❑ NOT EMPLOYED ❑

RESP. PARTY'S EMPLOYER:_____

MARITAL STATUS: SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED ❑ LEGAL. SEPARATED ❑

SIGNING BELOW AND CHECKING THE BOX INDICATES THAT:

- I understand that payment is due when services are rendered unless other arrangements are made in advance. I understand that I am financially responsible for prompt payment of all charges not covered or not paid by an insurance carrier or government agency.
- I hereby assign to Madison Foot & Ankle Care, P.A. all medical and surgical benefits to which I am entitled, for services performed by Dr. Barton or his staff.
- I hereby authorize this office to release any and all information as needed to secure payment on my behalf.
- I acknowledge that I have received a copy of the Payment Terms and Conditions.

☐ **I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.** The Notice of Privacy Practices contains a more complete description of the uses and disclosures of my personal health information.

_____ _____

SIGNATURE OF PATIENT (OR PARENT/LEGAL GUARDIAN IF UNDER 18) **TODAY'S DATE**

Please complete the back side of this form ⇨

REGISTRATION FORM CONTINUED

If you **did not** provide us with a copy of your insurance card(s), please fill out the information below.

INSURANCE INFORMATION

#1 INSURANCE COMPANY: _____

**** POLICY HOLDER'S NAME:** _____ **** DATE OF BIRTH:** _____

POLICY HOLDER'S ADDRESS: _____ **** PHONE #** _____

PATIENT'S RELATIONSHIP TO POLICY HOLDER: SELF❑ SPOUSE❑ CHILD❑ OTHER❑ (please specify)_____

POLICY #: _____ GROUP #: _____ POLICY EFFECTIVE DATE: _____

CLAIM ADDRESS: _____

INSURANCE CO. PHONE #: _____

#2 INSURANCE COMPANY: _____

**** POLICY HOLDER'S NAME:** _____ **** DATE OF BIRTH:** _____

POLICY HOLDER'S ADDRESS: _____ **** PHONE #** _____

PATIENT'S RELATIONSHIP TO POLICY HOLDER: SELF❑ SPOUSE❑ CHILD❑ OTHER❑ (please specify)_____

POLICY #: _____ GROUP #: _____ POLICY EFFECTIVE DATE: _____

CLAIM ADDRESS: _____

INSURANCE CO. PHONE #: _____