



REGISTRATION FORM

(Please Print)

Today's Date ____ / ____ / ____ Facility _____ Doctor _____

PATIENT INFORMATION

Patient's Last Name:		First	Middle	<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.	<input type="checkbox"/> Sr.
				<input type="checkbox"/> Dr.	<input type="checkbox"/> Miss	<input type="checkbox"/> Jr.
Street Address			City	State	Zip Code	
Home Phone ()		Work Phone ()		Cell Phone ()		
Birth Date	Age	Social Security Number		Marital Status		Sex
				Single	Married	<input type="checkbox"/> M <input type="checkbox"/> F
Email address			Occupation			

EMERGENCY CONTACT

Name	Phone	Secondary Phone
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INSURANCE INFORMATION

Please indicate primary insurance	Address of primary insurance carrier	Phone Number
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Insured Employer _____

Insured Employer Address _____

Insured Name	Insured S.S.#	Insured ID	Policy Group #	Insured Birthdate: / /	Co-Payment \$
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Patient's Relationship to Insured
 Self Spouse Child Other

Insurance Type PPO HMO Self Pay Medicare WC OTHER _____

Please indicate secondary insurance	Address of secondary insurance carrier	Phone Number
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Insured Name	Insured S.S.#	Insured ID	Policy Group #	Insured Birthdate: / /	Co-Payment \$
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Patient's Relationship to Insured
 Self Spouse Child Other

Insurance Type PPO HMO Self Pay Medicare WC OTHER _____

Referred to Institute by (Please use one)
 Doctor Hospital Insurance Plan Family Friend Other _____

Please Indicate Referral Source _____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
To First Step Foot Care, SC

x _____
Signature **Date**

HIPAA AUTHORIZATION
 Necessary to process claims

x _____
Signature **Date**