Westside Podiatry
PATIENT REGISTRATION FORM

This information is confidential

PATIENT INFORMATION

Name____

Address____

Apartment Number_________________________________

City____

State____________________ Zip____________________

Telephone (_______) ______________________________

E-mail:____

Social Security #_________________________________

Date of Birth:___________________ ☐Male ☐Female

☐ Single ☐ Married ☐ Widowed ☐ Divorced

☐ American Indian or Alaska Native ☐ Asian ☐ White

☐ Black or African American ☐ Native Hawaiian ☐ Cuban

☐ Hispanic Latino/a ☐ Another Hispanic or Spanish Origin

☐ Mexican, Mexican American, or Chicano/a

☐ Puerto Rican ☐ Other

Occupation ______________________________________

Employer ____

Address ____

____

Work Phone (_______)________________Ext_________

Cell Phone (________) ____________________________

Spouse Information (If Applicable)

Name ____

Home Phone ______________________________________

Work Phone ____________________________Ext_______

Primary Care Physician

Primary Physician_________________________________

Referring Physician_______________________________

Date Last Seen __________________________

INSURANCE INFORMATION

Primary- Ins. Co. Name____________________________

Policyholder Name_________________________________

☐ Self ☐ Spouse ☐ Parent

Policyholder's Date of Birth_____/______/______

Employer____

Secondary- Ins. Co. Name__________________________

Policyholder Name_________________________________

Policyholder's Date of Birth_____/______/______

☐ Self ☐ Spouse ☐ Parent

PHARMACY INFORMATION

Pharmacy Name_____________________________________

Address____

City______________________ State________________

Phone ____

EMERGENCY CONTACT (If other than spouse)

Name____

Relationship_____________________________________

Telephone (________)______________________________

Parent/ Guardian Information (if patient is under age 18)

Name____

Address____

City____

State______________________ Zip__________________

Telephone (__________) ___________________________

SS#___________________________DOB______________

Occupation_______________________________________

Employer____

Address____

Work Phone(_________)________________Ext_________

Westside Podiatry
PATIENT REGISTRATION FORM

Is your treatment today due to:

……………a work related injury ☐ Yes ☐ No Injury Date________________________________

Do you have written authorization from your employer and comp carrier to be treated? ☐ Yes ☐ No

……………a motor vehicle accident ☐ Yes ☐ No Accident Date______________________________

……………an accident/ liability case ☐ Yes ☐ No Accident Date______________________________

Whom may we thank for sending you to our office?

☐ Doctor____

☐ Patient____

☐ Newspaper____________________________________

☐ Other____

☐ Web site: ____

☐ The Yellow Book

☐ Insurance Provider List

☐ Passed by Location ☐ Health Fair

I hereby authorize the release of any medical information pertaining to my treatment or information necessary for processing insurance claims and payment of medical benefits to myself or the party who accepts assignments. This authorization will remain valid until revoked by me in writing. I understand that I am legally responsible for all charges whether or not reimbursed by my insurance company.

Signature X____ Date_____________________________________

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf of **Westside Podiatry** for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT’S NAME (Please Print)		**PROVIDER: Name, Address, and Zip**
		Westside Podiatry **11307 FM 1960 W** **Suite 300** **Houston, TX 77064**
PATIENT’S SIGNATURE :		
PATIENT’S MEDICARE NO.	DATE:	