Carolina Foot Care, LLC
Registration Form

Patient Information

Patient Name(Last, First, MI)	Home Telephone	Cell Phone	Social Security Number
	( )	( )	

Mailing Address	Primary Care Physician Name Address Phone Number

City	State	ZIP	Date of Birth	Age	Sex
					☐ M ☐ F

Employer Name Address Phone Number	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	Patient Student Status ☐ Full Time ☐ Part Time ☐ Not a Student

Marital Status ☐ Divorced ☐ Married ☐ Widowed ☐ Separated ☐ Single

Emergency Contact

Name: _____ Phone__(_____)_____

Relationship_____

Required for Reporting Purposes:

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Non Latino ☐ Decline to Specify

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ African American ☐ Hispanic ☐ White ☐ Other ☐ Decline to Specify

Email address: (used only for appointment reminders)

Responsible Party for Billing (if patient is a minor)

Responsible Party Name	Home Telephone	Cell Phone	Social Security Number
	( )	( )	

Mailing Address	Date of Birth	Patient Relationship to Responsible Party
		☐ Self ☐ Spouse ☐ Child ☐ Other _____

City	State	ZIP	Employer Name Address Phone Number

Primary Insurance

Subscriber Name	Date of Birth	Patient Relationship
		☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Carrier	Group Number	Policy ID Number	Does your insurance require a referral to see a specialist? ☐ Yes ☐ No

Secondary Insurance

Subscriber Name	Date of Birth	Patient Relationship
		☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Carrier	Group Number	Policy ID Number	Does your insurance require a referral to see a specialist? ☐ Yes ☐ No

Insurance Assignment and Release: I authorize Carolina Foot Care, LLC to render necessary treatment to the above named patient. I authorize direct payment to Carolina Foot Care, LLC of any insurance benefits otherwise payable to, on, or behalf of the patient for all medical services. It is understood that I am financially responsible for the charges not covered by this assignment. Authorization is also given to release any and all medical information to the insurance companies involved to allow them to process any claims for all services rendered.

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Patient/Parent/Guardian Signature Relationship if other than patient Date