REGISTRATION **Advanced Foot and Ankle of WI, LLC**

PATIENT INFORMATION *(please print & complete all areas)*

Name _____ **SSN** ___-___-___
Last First MI

Address _____ City _____ State____ Zip____

Home # (___)_____ **Work #** (___) _____ **Cell #** (___) _____

*List only numbers we have consent to call

Email Address:_____

☐ Male ☐ Female **Date of Birth** ____/____/____ ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Age _____ **Ethnicity** ☐ African- American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other

Employer _____ **Occupation**_____

Employer Address_____

Spouse's Name_____ **Spouse's SSN**___-___-___

Spouses Employer_____**Date of Birth**___/___/___

Referring Doctor's Name_____ **Primary Doctor's Name**_____

Date of last appointment with Primary Care Doctor____/____/____

Emergency Contact_____**Phone #** (___)_____**Relationship**_____

INSURANCE

Person Responsible for Account / Insured_____
Last First MI

Primary Insurance_____ **Secondary Insurance**_____

Policy Holder Name_____ **Policy Holder Name**_____

Subscriber #_____ **Subscriber #**_____

Group #_____ **Group #**_____

** ***If patient is the <u>SPOUSE/CHILD OF THE INSURED</u>, the parent's information must be completed below:***

SSN ___-___-___ DOB___/___/___Home # (___)_____Relationship_____

Address _____ City_____State_____Zip_____

Employer _____Work #_____

ASSIGNMENT AND RELEASE

I certify that I (or my dependent) have insurance coverage with aforementioned insurance carrier(s) and assign directly to my doctor all insurance benefits, if any, otherwise payable to me for services rendered. ***I understand that I am financially responsible for all charges whether or not paid by my insurance and accept responsibility for any balance remaining after payment of such benefits.*** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature of all my insurance submissions. I further authorize the physician to release any information required in the course of my treatment as authorized according to HIPAA Privacy Rules.

_____ _____ _____
Signature of Insured or Guardian Relationship Date