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**______/______/______

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