Patient Registration Form

Completed forms may be submitted to our office prior to your appointment. All forms can be faxed to our confidential fax at 828-697-3224.

Patient Information (PLEASE complete all applicable spaces)

Full First Name: _____ MI: _____ Last Name: _____
Physical Address: _____
City: _____ State: _____ Zip: _____
Alternate/Billing Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Best time and place to reach you: _____E-Mail Address: _____
Age: _____ Birth Date: _____ Gender: M/F Social Security #: _____ Marital Status: _____
Employer Name/Address: _____ or Student: Yes/No
Chief Complaint: _____ Occurrence Date: _____ Related to: Work: Yes/No Auto: Yes/No Accident: Yes/No
Full Name of Family Doctor: _____ Date last seen: _____ Phone:_____

Primary Insurance (IN ADDITION to a copy of the insurance card)

Insurance Name: _____
Insurance Phone # for eligibility: _____ Claims address: _____
Policy/Member ID: _____ Group/Account #: _____
Primary Insured's Full Name: _____ Date of Birth: _____ Gender: M/F SS #: _____
Primary Insured's home address: _____
Employer's Name: _____ Phone: _____
Employer's Address: _____

Secondary Insurance (ONLY if patient has Medicare as a primary/secondary)

Insurance Name: _____ If necessary did you bring your referral: Yes/No/NA
Insurance Phone # for eligibility: _____ Claims address: _____
Policy/Member ID: _____ Group/Account #: _____
Primary Insured's Full Name: _____ Date of Birth: _____Gender: M/F SS #: _____
Primary Insured's home address: _____
Employer's Name: _____ Phone: _____
Employer's Address: _____

Privacy Information

Can we leave messages at any of the above listed numbers? Home: Yes/No Work: Yes/No Cell: Yes/No
Emergency Contact Name: _____ Relationship: _____ Phone: _____
Names of family/friends who can pick up your records and/ medical supplies: _____
Names of family/friends who have parents' authorization to bring in the Minor child when guardian is absent:
_____

Consent

I certify that the above and attached information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary to the diagnosis and/or treatment of me or my child's condition. As a representative of myself or as a guardian, I give authorization for the above listed patient to receive medical and/or surgical care and treatment with any of the Doctors at Hendersonville Podiatry.

Printed Patient's Name: _____ Representative's Signature: _____ Date: _____