PORT WASHINGTON PODIATRY

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION			
Patient's last name: First: Middle: Birth date: ___/___/___ Age: Sex: ☐ M ☐ F	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: (please mark a box below) Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Street address: (please write below)	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:
Occupation:	Employer:		Employer phone no.: ( )

Chose clinic because/referred to clinic by (Please check one box):	☐ Dr.	☐ Insurance plan	☐ Hospital	
☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other

PHARMACY NAME________________________________EMERGENCY CONTACT__________________________

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )
Is this person a patient here?	☐ Yes ☐ No		
Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance?	☐ Yes ☐ No	Please indicate primary insurance:			
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	Pharmacy Name:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other