PATIENT REGISTRATION with Foot and Ankle Associate of North Texas
Use black ink. Submit 2 days prior via HIPAA fax: 817-886-3612

Last Name	**Legal First Name**	**MI**	
Physical Address	**City**	**State**	**Zip**
Home Phone (_____) ______-________	**Work Phone** (_____) ______-________	**Cell Phone** (_____) ______-________	**Email**
Date of Birth ______/______/______	**Social Security #** ________-______-________	**Gender** □ Male □ Female	**Marital Status** □ Single □ Married □ Other

Primary Language

Race □ Not Specified
□ American Indian □ Asian □ Alaska Native
□ Black/African American □ Native Hawaiian □ White

Ethnicity □ Not Specified
□ Hispanic/Latino
□ Not Hispanic/Latino

Employment
□ Full-Time □ Part-Time □ Retired □ Unemployed

Employer Name

Emergency Contact Name	**Relationship** □ Family □ Friend □ Spouse	**Home Phone** (_____) ______-_______	**Cell Phone** (_____) ______-________

Primary Care Physician

Office Phone
(_____) ______-_________

Referred By
□ Friend □ Insurance □ Internet □ Magazine
□ Newspaper □ Phone Book □ Referring Dr

Your claim is □ Compensable/Work Related □ Automobile □ Other Liability □ Not Related Work/Auto/Liability

Primary Insurance– copy of card required for claim

Insurance Name	**Eligibility Phone** (_____) ______-__________
Medical Claims Address	
Insured Name	**Relationship to Insured** □ Self □ Spouse □ Child
Insured Date of Birth ______/______/______	**Insured Social Security #** ________-______-________
ID #	**Group #**
Insured Employer Name	**Employer/HR Phone #** (_____) ______-__________

Secondary Insurance– only when Medicare is 1st or 2nd

Insurance Name	**Eligibility Phone** (_____) ______-__________
Medical Claims Address	
Insured Name	**Relationship to Insured** □ Self □ Spouse □ Child
Insured Date of Birth ______/______/______	**Insured Social Security #** ________-______-________
ID #	**Group #**
Insured Employer Name	**Employer/HR Phone #** (_____) ______-__________

Privacy Information

Circle phone number and time of day where we can contact/leave you message(s)? Home: AM/PM Work: AM/PM Cell: AM/PM

Name person(s) who can have access to your records/PHI or pick up items for you:____

Attest

I do hereby attest that this information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of any material fact may subject me to all fees for services and/or other liability. I also understand that I am to notify Foot and Ankle Associates immediately of any changes to the above information and annually upon the office's request.

____ ______________________ ________________ __________

Print Name of Patient or Legal Authorized Representative | Signature | Relationship to Patient | Date