Foot and Ankle Associate of North Texas—PATIENT REGISTRATION

Legal First Name **MI** **Last Name**

Date of Birth ______/______/______
Gender □ Female □ Male
Social Security # ________-______-________
Marital Status □ Never Married □ Married □ Divorced □ Domestic Partner

Race □ American Indian/Alaska Native □ Asian □ Black/African American □ Hispanic □ Native Hawaiian □ White

Primary Language: _______________ **Ethnicity** □ Hispanic/Latino □ Not Hispanic/Latino □ Patient Declined

Physical Address **City** **State** **Zip**

Employment
□ Employed □ Unemployed □ Student □ Other/Retired
Employer Name

Home Phone (_____) ______-________
Work Phone (_____) ______-________
Cell Phone (_____) ______-________
Email

Mark Preferred Method of Call/Voice Mail
□ Home Phone □ Work Phone □ Cell Phone

Mark Preferred Method of Written Correspondence
In addition to FAANT's Secure Pt Portal □ Email □ Postal Service

Emergency Contact Name
Relationship □ Mother □ Father □ Friend □ Spouse □ __________
Home Phone (_____) ______-_______
Cell Phone (_____) ______-________

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

Primary Care Physician
Office Phone (_____) ______-_________
Referred By □ ER □ Friend □ FAANT Foot/Run Book □ Insurance □ Internet □ PCP/Refer Dr □ TX Ortho TOS

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

Primary Insurance– copy of card required for claim		**Secondary Insurance– when Medicare/Tricare is 1st/2nd**	
Insurance Name	**Eligibility Phone** (_____) ______-__________	**Insurance Name**	**Eligibility Phone** (_____) ______-__________
Medical Claims Address		**Medical Claims Address**	
Member ID #	**Group #**	**Member ID #**	**Group #**
Insured Name	**Relationship to Insured**	**Insured Name**	**Relationship to Insured**
Insured Date of Birth ______/______/______	**Insured Social Security #** _________-_______-_________	**Insured Date of Birth** ______/______/______	**Insured Social Security #** _________-_______-_________
Insured Employer Name	**Employer/HR Phone #**	**Insured Employer Name**	**Employer/HR Phone #** (_____) ______-__________

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