

# REGISTRATION INFORMATION

PLEASE PRINT CLEARLY. COMPLETE ALL BLANKS AND SIGN BELOW.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Sex: M F Marital Status: S M D W Social Security #: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Person Responsible for Payment \_\_\_\_\_ Relationship \_\_\_\_\_  
Patient's Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Primary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Insured's Occupation \_\_\_\_\_ Employer name/address \_\_\_\_\_  
Secondary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Who do we call in case of an emergency? Name \_\_\_\_\_  
Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

## HOW DID YOU FIND OUT ABOUT OUR OFFICE?

Dr. \_\_\_\_\_ referred me Mr/Mrs/Ms \_\_\_\_\_ referred me  
Yellow Pages Outside Sign I'm a Previous Patient Advertisement in/on the \_\_\_\_\_  
PPO Directory Other \_\_\_\_\_

## Please circle ALL painful symptoms you are experiencing and their location

ARCH PAIN: RIGHT/LEFT ANKLE PAIN: RIGHT/LEFT BUNIONS: RIGHT/LEFT CRAMPS: RIGHT/LEFT  
HEEL PAIN: RIGHT/LEFT PAINFUL CALLOUS: RIGHT/LEFT PAINFUL CORNS: RIGHT/LEFT  
ITCHING/SWELLING REDNESS: RIGHT/LEFT ULCERS: RIGHT/LEFT OTHER \_\_\_\_\_  
INGROWN NAIL: RT/LT 1 2 3 4 5 TOES THICK PAINFUL NAIL: RT/LT 1 2 3 4 5 TOES

How long have you had pain: \_\_\_\_\_

Please rate your pain from 1 to 10, with 10 being the worst: \_\_\_\_\_

Please circle one: No pain Mild Moderate Severe

We do our best to obtain accurate information regarding your insurance coverage but please note that the description given to us by your insurance company is an estimate of benefits only and is not a certification or guarantee of payment. All claims submitted are subject to limitations, provisions and exclusions outlined in your plan. Coverage and payment are dictated at the time the claim is processed. Therefore, you may be responsible for more than you/we are told at the time of treatments, and assignment of benefits when applicable. STATEMENT: I understand that if I fail to keep any financial agreement I make with this Practice, and my account must be sent to a collection agency, I will be responsible for all collection costs and legal fees incurred. I agree to allow Foot Center McAllen Weslaco PLLC to access my past medical history.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR LEGAL GUARDIAN

\_\_\_\_\_  
DATE