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: _____
Home/Mailing Address: _____
Work Phone: _____ email address: _____
Person Responsible for Payment _____ Relationship _____
Patient's Occupation _____ Employer name/address _____
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 Outside Sign ___ The Monitor App ___ Billboard ___
PPO Directory ___ Social Media _____ Google ___ Friend ___ Family ___

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**