PATIENT REGISTRATION FORM

PLEASE PRINT - WRITTEN INFORMATION WILL NOT BE ACCEPTED.
ALL INFORMATION IS CONFIDENTIAL.

PATIENT INFORMATION ❑ Male ❑ Female ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Name _____

Address _____ Apartment / Unit _____

City _____ State _____ Zip _____ Telephone (___) _____

Cell Phone # (___) _____ Occupation _____

Social Sec. Number _____ Birth Date _____ Drivers License # _____ State Issued _____

Employer _____ Work Phone # _____ Ext. _____

Address _____ Apartment / Unit _____

City _____ State _____ Zip _____ Telephone (___) _____

Emergency Contact _____ Relationship _____

Phone _____ Ext. _____

How did you hear about the Cleveland Foot and Ankle Clinic? _____

_____

What is the reason for your visit today? _____

_____

INSURANCE INFORMATION

I will be paying today by: ❑Cash ❑Check ❑Credit Card
Do you have medical insurance?: ❑ Yes ❑ No
Is your insurance an HMO? ❑ Yes ❑ No

Primary - Ins. Co. Name _____
Policyholder: _____
Policy # _____
Group # _____
Address _____
DOB _____ Employer _____
Secondary Ins. _____
Policyholder: _____
Policy # _____
Group # _____
Address _____
DOB _____ Employer _____

RESPONSIBLE PARTY

Name _____
Address _____
Apartment / Unit _____
City _____ State _____
Zip _____ Telephone (___) _____
Social Security # _____
DOB _____
Occupation _____
Employer _____
Address _____
Work Phone _____ Ext. _____

PLEASE COMPLETE REVERSE SIDE OF FORM

ASSIGNMENT and RELEASE

NO INFORMATION PERTAININIG TO YOUR CARE WILL BE RELEASED TO ANY OTHER ENTITY WITHOUT YOUR SPECIFIC AUTHORIZATION.

I , the undersigned, have insurance coverage with the named Insurance Carrier(s) and assign directly to **Cleveland Foot and Ankle Clinic** all medical benefits, if any - otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all my insurance submissions.

_____ _____

SIGNATURE DATE

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the **Cleveland Foot and Ankle Clinic**, for any services furnished me by **Cleveland Foot and Ankle Clinic**. I authorize any holder of my medical information to release it to the Health Care Financing Administration and its agents any information necessary to determine these benefits or benefits payable for related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA - 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, **Cleveland Foot and Ankle Clinic** agrees to accept the charge determination of the Medicare carrier as the full charge. The patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductibles are based upon the charge determination of the Medicare carrier.

_____ _____

BENEFICIARY SIGNATURE DATE

PLEASE ATTACH COPIES OF ALL INSURANCE CARDS, **FRONT AND BACK**