

Chart # \_

# **REGISTRATION FORM**

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Patient's last name:			First:				Middle:			🗆 Mr. 🗆 Mi		s	Marital status (circle one)					
										Mrs.	D Ms.		Single / Mar / Div /		Sep / Wid			
Is this your legal name? If not, w				/hat is your legal name?			(Fo	(Former name):				Birth da		te:	Ag	ge:	Sex:	
□ Yes	D No												/	/			ПM	ΠF
Street address:		1						Social Se	curity no.:					Home p	hone no	.:		
														(	)			
														Cell pho	one no.:			
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														Email A	ddress:			
P.O. box:			City	:							State:				ZIP Cod	e:		
Occupation:			Emp	oloyer:										Employe	er phone	no.:		
														(	)			
Chose clinic beca	use/Referred t	o clinic by	(pleas	(please check one box):				Dr.					Insurance Plan     Hospit			pital		
Family	Friend	🗖 Cle	ose to home/work			Yello	Ilow Pages   Other				er							
Other family men	mbers seen her	e:																
PRIMARY CARE	E PHYSICIAN	NAME:																
ADDRESS:																		
TELEPHONE :																		
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Pharmacy Name:			Add	ress:										Phone r				
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FOOT CENTER of NEW YORK 55 EAST 124<sup>th</sup> St. NY, NY 10035 Phone 212.410.8158 Fax 212.410.8166

Cancer	Leg/Foot swelling	Fractures Specify:	Hernia
Diabetes	Congestive heart failure	Arthritis	Heartburn/reflux
High blood pressure	Leg/Foot numbness	Sprained ankle/foot	Stomach ulcer
High cholesterol	Burning or tingling	Rheumatoid arthritis	Jaundice
Heart attack	Sciatica	Fibromyalgia	Pancreatitis
Stroke	Weakness	Neuromuscular disease	Asthma
Blood clots	Seizures	Frequent urinary infections	Emphysema
Poor circulation	Back pain, hip/knee pain	Kidney disease or dialysis	Pulmonary ambrosias
HIV	Hepatitis	Rheumatic fever	Cellulites or Gangrene
Blood poisoning	Polio	Depression	Anxiety
Bipolar Disorder	Developmental abnormality	Allergies	
	Specify:	Specify:	

Reason for visit today \_\_\_\_

Is the problem related to a: car accident Y or N OR work related Y or N

\_\_ Duration \_\_\_

### 1. Financial Responsibility:

I agree to be fully responsible for all bills of all the services given to me at The Foot Center of New York.

### 2. Approval Of Use of Authorization Copy:

I approve of a copy this authorization being used instead of the original.

## 3. Assignment Of Insurance Benefits:

I request payment of medical insurance benefits to myself or to the party named above who accepts assignments.

### 4. Authorization For Release of Medical and Other Information Related To Patient:

I authorize The Foot Center of New York to release medical or any other information about me to Medicare, its intermediary, or other commercial insurance companies.

# 5. Acknowledgement of Receipt of Privacy Notice:

I acknowledge that I was provided a copy of the Notice of Privacy and that I have read (or had the opportunity to read if I so choose) and understood the notice.

	ORIGINAL SIGNATURES	
		Date
Patient/Guardian signature		
Witness signature		Date

# Registration Completed By\_\_\_\_\_