

Chart # _

REGISTRATION FORM

_

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.:			
														()			
														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 :																		
					F	PHAR	ИАС	Y INFC	RMATI	ON								
Pharmacy Name:			Add	ress:										Phone r				
, , , , , , , , , , , , , , , , , , ,														()			
					I	NSUR	ANG	CE INFO	ORMAT	ION	J		, in the second s					
					(5)		r inci	iranco cai	d to the r	ecer	otionist.)						
					(Please g	jive you			u to the i	CCCF								
Person respons	sible for bill:	Birt	h dat	e:		give you ss (if dif				ccck				Home	phone r	10.:		
Person respons	sible for bill:	Birt	h dat /	e: /										Home (phone r)	10.:		
Person responses			/											Home (phone r)	10.:		
-		e? 🗖 \	/	/ □ No		ss (if dif								(phone r) /er phoi			
Is this person a	a patient here	e? 🗖 \	/	/ □ No	Addres	ss (if dif								()			
Is this person a	a patient here Emplo	e? 🗖 \ oyer:	/ ′es	/ D No Emplo	Addres	ss (if dif								(Employ)			
Is this person a Occupation:	a patient here Emplo	e? 🗆 \ iyer: isurance?	/ ′es	/ No Emplo Yes	Addres yer addre	ss (if dif	ferer	nt):	Cigna		GHI			(Employ ()			
Is this person a Occupation: Is this patient o Please indicate	a patient here Emplo	e? In the second secon	/ ′es □ □ A	/ No Emplo Yes	Addres yer addre	ss (if dif	ferer	nt):	Cigna		GHI Other			(Employ ()			
Is this person a Occupation: Is this patient o Please indicate	a patient here Emplo covered by in primary insu United Hea	e? I) yer: surance?	/ /es 	/ Physical No Emplo Yes etna Oxford	Addres yer addre	ss:	ferer	it):	Cigna care					(Employ () /er phoi		Со-ра	yment:
Is this person a Occupation: Is this patient o Please indicate I 1199	a patient here Emplo covered by in primary insu United Hea	e? I) yer: surance?	/ /es 	/ Physical No Emplo Yes etna Oxford	Addres yer addre	ss:	Frerer /BS Birth	nt):	Cigna care		Other			(Employ (P) /er phoi		Co-pay \$	/ment:
Is this person a Occupation: Is this patient o Please indicate I 1199	a patient here Emplois covered by in primary insu United Heat ame:	e? • \ nyer: nsurance? nrance althcare	/ /es Ad Subs	/ Physical No Emplo Yes etna Oxford	Addres	ss:	7/BS Birth	nt):	Cigna care	Grou	Other			(Employ (P) /er phoi			/ment:
Is this person a Occupation: Is this patient o Please indicate □ 1199 0 Subscriber's na	Emplo Emplo covered by in primary insu United Heat ame:	e? • • • • • • • • • • • • • • • • • • •	/ /es Ad Subs	/ No Emplo Yes etna Oxford Scriber's Self	Addres	ss: BC edicaid Spouse	iferer //BS Birth	nt):	Cigna care	Grou	Other up no.:	G	D HI	(Employ (P Policy I) /er phoi		\$	/ment:
Is this person a Occupation: Is this patient o Please indicate 1199 0 Subscriber's na Patient's relatio	Emplo Emplo covered by in primary insu United Heat ame:	e? • • • • • • • • • • • • • • • • • • •	/ /es Ad Subs	/ No Emplo Yes etna Oxford Scriber's Self	Addres	ss: BC edicaid Spouse	iferer //BS Birth	nt):	Cigna care	Grou	Other up no.:	Gı		(Employ (P Policy I) /er phoi	ne no.:	\$	/ment:
Is this person a Occupation: Is this patient o Please indicate 1199 0 Subscriber's na Patient's relatio	a patient here Emploin covered by in primary insu United Heat ame: posship to sub idary insurant	e? • • • • • • • • • • • • • • • • • • •	/ /'es Arian Subs []icabl	/ No Emplo Yes etna Oxford Scriber's Self	Addres	ss: BC edicaid Spouse	iferer //BS Birth /	nt):	Cigna care	Grou	Other up no.:	Gī		(Employ (P Policy I) /er phoi	ne no.:	\$	/ment:
Is this person a Occupation: Is this patient o Please indicate □ 1199 0 Subscriber's na Patient's relation Name of secon	a patient here Emploin covered by in primary insu United Heat ame: posship to sub idary insurant	e? • • • • • • • • • • • • • • • • • • •	/ /'es Arian Subs []icabl	/ No Emplo Yes etna Oxford Scriber's Self le):	Addres	ss: BC edicaid Spouse er's nam Spouse	Ferer	nt): Media date: / / Child	Cigna care	Grou	Other up no.: Dther	Gr		(Employ (P Policy I) /er phoi	ne no.:	\$	/ment:
Is this person a Occupation: Is this patient o Please indicate □ 1199 0 Subscriber's na Patient's relation Name of secon	a patient here Emploin covered by in primary insu United Hea ame: onship to sub idary insurant onship to sub	e? yyer: surance? asurance? althcare scriber: ce (if app scriber:	/ /'es Arian Subs []icabl	/ No Emplo Yes etna Oxford Scriber's Self le):	Addres	ss: BC edicaid Spouse er's nam Spouse	Freer Birth	nt): Media date: / / Child OF EMI	Cigna care		Other up no.: Dther			(Employ (P Policy I	yer phor) no.:	Polic	\$	
Is this person a Occupation: Is this patient o Please indicate □ 1199 0 Subscriber's na Patient's relatio Name of secon	a patient here Emploin covered by in primary insu United Hea ame: onship to sub idary insurant onship to sub	e? yyer: surance? asurance? althcare scriber: ce (if app scriber:	/ /'es Arian Subs []icabl	/ No Emplo Yes etna Oxford Scriber's Self le):	Addres	ss: BC edicaid Spouse er's nam Spouse	Freer Birth	nt): Media date: / / Child OF EMI	Cigna care		Other up no.: Dther		roup no	(Employ (P Policy I	yer phor) no.:	Polic	\$ / no.:	
Is this person a Occupation: Is this patient o Please indicate □ 1199 0 Subscriber's relatio Name of secon Patient's relation Name of local f	a patient here Emploined covered by in primary insu United Hea ame: onship to sub idary insurant onship to sub	e? yyer: surance? asurance? althcare scriber: ce (if app scriber: tive:	/ /es Ad Subs	/ I No Emplo Yes etna Oxford scriber's I Self le): I Self	Addres	ss: BC edicaid Spouse er's nam Spouse	iferer //BS Birth / ee: ASE F	at): Media date: / / Child OF EMI Relationsh	Cigna care ERGEN(ip to patie	Grou Grou CCY ent:	Other up no.: Dther Dther	Ho (roup no pme pho)	(Employ (P Policy I) /er phoi) no.:	Policy /ork pho)	\$ / no.:	
Is this person a Occupation: Is this patient o Please indicate □ 1199 0 Subscriber's na Patient's relatio Name of secon	a patient here Emploined covered by ir primary insu United Heat ame: Donship to sub idary insurant onship to sub friend or relation	e? Average of the second seco	/ /es Ad Subs licabl	/ No Emplo Yes etna Oxford scriber's Self le): Self le): Self le):	yer addres yer addres No S.S. no.: Subscribe	ss: BC edicaid Spouse er's nam Spouse	iferer //BS Birth / ee: ASE F	at): Media date: / / Child OF EMI Relationsh	Cigna care ERGEN(ip to patie	Grou Grou CCY ent:	Other up no.: Dther Dther	Ho (roup no pme pho)	(Employ (P Policy I) /er phoi) no.:	Policy /ork pho)	\$ / no.:	
Is this person a Occupation: Is this patient o Please indicate □ 1199 0 Subscriber's na Patient's relatio Name of secon Patient's relation Name of local f	a patient here Emploined covered by ir primary insu United Heat ame: Donship to sub idary insurant onship to sub friend or relation	e? Average of the second seco	/ /es Ad Subs licabl	/ No Emplo Yes etna Oxford scriber's Self le): Self le): Self le):	yer addres yer addres No S.S. no.: Subscribe	ss: BC edicaid Spouse er's nam Spouse	iferer //BS Birth / ee: ASE F	at): Media date: / / Child OF EMI Relationsh	Cigna care ERGEN(ip to patie	Grou Grou CCY ent:	Other up no.: Dther Dther	Ho (roup no pme pho)	(Employ (P Policy I) /er phoi) no.:	Policy /ork pho)	\$ / no.:	



FOOT CENTER of NEW YORK 55 EAST 124th 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_____