

PATIENT REGISTRATION FORM

DATE _____ HOME PHONE _____ CELL PHONE _____ GENDER M _____ F _____

PATIENT'S NAME _____
LAST FIRST MIDDLE INITIAL

ADDRESS _____
NUMBER & STREET CITY STATE ZIP CODE

BIRTHDATE _____ AGE _____ WEIGHT _____ SHOE SIZE _____ DRIVER'S LICENSE _____

SOCIAL SEC # _____ EMAIL ADDRESS _____

REFERRED BY:

DOCTOR _____ PHONE BOOK _____ FRIEND/RELATIVE _____ OTHER _____

PATIENT'S EMPLOYER _____ OCCUPATION _____ WORK PHONE _____

NAME OF SPOUSE/PARENT _____ EMPLOYER _____ WORK PHONE _____

IF WORK RELATED, DATE OF INJURY _____ CLAIM NUMBER _____

PRIMARY INSURANCE CO. _____ PHONE NUMBER _____

ADDRESS _____
NUMBER & STREET CITY STATE ZIP CODE

NAME OF INSURED _____ D.O.B. _____ GROUP# _____ ID# _____

SECONDARY INSURANCE CO. _____ PHONE NUMBER _____

ADDRESS _____
NUMBER & STREET CITY STATE ZIP CODE

NAME OF INSURED _____ D.O.B. _____ GROUP# _____ ID# _____

*FAMILY DOCTOR _____ PHONE _____

EMERGENCY CONTACT _____ PHONE _____

PLEASE READ THE FOLLOWING: I hereby give my permission for Dr. Gerald Peterson and/or his assistants to administer treatment as may be deemed necessary in the diagnosis and/or treatment of any podiatric medical condition.

OFFICE POLICIES

All non-covered services are due at the time of service. As a courtesy to me, my insurance claim will be processed provided all necessary information is presented. I understand that if my insurance company requires that my primary care physician refer me to Dr. Peterson and I have not obtained that referral, that any and all charges incurred will be, my responsibility. I also understand that I must notify Dr. Peterson of any need to pre-authorize treatment, and I accept responsibility for all charges which pre-authorization is not obtained. **COPAYMENTS ARE DUE AT THE TIME OF SERVICE.** Statements are sent out monthly. My account will be assessed a rebilling charge of \$5.00 per month for any balance over 60 days. Balances are not carried over 90 days. If my insurance company has not paid within that time frame, the balance over 90 days will become my responsibility. If payment does not result, my account will be assigned to collections. I understand that if it becomes necessary to use outside collection efforts to bring my account to a paid status, that I will be charged any and all collection costs at the time the account is assigned. Also, I hereby authorize any insurance benefits to be payable directly to the physician. I am financially responsible for all non-covered charges. I also authorize the physician to release any medical information necessary in processing my insurance claim to my insurance company. A charge of \$30.00 will be added to all returned checks.

SIGNATURE OF PATIENT OR AUTHORIZED PERSON _____