Greenville Foot & Ankle Center LLC

PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Mrs. ☐ Dr. ☐ Miss ☐Ms.	Marital Status (Circle One) Single/ Mar /Div /Sep/ Wid
Nickname (Name I prefer to be called)			Birthdate (mm/dd/yyy)	Spouse's Name
Street Address			Social Security #	Home Phone # ( )
City	State	Zip Code	E-Mail	Mobile Phone # ( )
Employer	Employer Address			Employer/Work Phone # ( )
Pharmacy Name & Phone Number			Primary Care Physician	

INSURANCE INFORMATION

Primary Insurance			Subscriber Name	
Insurance ID #	Group #	Policy #	Effective Date	Co-Payment $

IN CASE OF EMERGENCY

Name of Nearest Friend or Relative	Relationship to Patient	Home Phone # ( )	Work or Mobile Phone # ( )

REFERRAL

Who may we thank for referring you to our Center? _____

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The above information is true to the best of my knowledge. I certify that I have Insurance with the insurance company(ies) disclosed and assign directly to Greenville Foot & Ankle Center, LLC all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether paid or not paid by my insurance. I authorize the use of my signature below on all insurance submissions. Greenville Foot & Ankle Center may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X_____

Patient/Guardian Signature Date