Deanna Lynn Inlow, DPM

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:

City/State/Zip Code	Preferred Language: (circle one) English Spanish Other:

Home phone: ( )	Cell phone: ( )	Work phone: ( )	Email address:

Employer:	Occupation:	Employer phone no.: ( )

Emergency contact name:	Emergency contact relation:	Emergency contact phone number: ( )

Ethnicity: ❑ Central American ❑ Cuban ❑ Dominican ❑ Hispanic or Latino/Spanish ❑ Mexican ❑Puerto Rican ❑ Latin American/Latin, Latino ❑ South American ❑ Not Hispanic or Latino ❑Decline

Race: ❑ Black or African American ❑ Asian ❑ European ❑ White ❑ Filipino ❑ Other race ❑Decline

I authorized my healthcare provider, or representative, to discuss any healthcare and/or financial information with the following individuals.

Name:_____ Relationship: _____ Date of birth: / /

GUARDIAN INFORMATION (IF PATIENT IS A MINOR)

Name of Parent / Guardian:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Address: Street / City / State / Zip Code: (IF SAME AS PATIENT – CHECK HERE ❑)

GUARANTOR INFORMATION

Guarantor responsible for bill:	Birth date: / /	SSN:	Guarantor phone no: ( )
Relationship of Guarantor:	Guarantor address : (IF SAME AS PATIENT – CHECK HERE ❑)		Guarantor Employer: ( )

1ST INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Name of primary insurance (if applicable):	Subscriber's name:	Subscriber's Birth date: / /	Policy no.: Group no.:

Subscriber's S.S. no.:	Co-Payment: $	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

2ND INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Subscriber's Birth date: / /	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

DISCLOSURES / AUTHORIZATIONS

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorized payment directly to the Physician for any amount due to me for professional services, including major medical, under this claim. The authorization is to remain in effect until revoked by me in writing. I further authorize you to notify directly to the Physician of any rejections of this claim. I understand that regardless of my insurance status, I am ultimately financially responsible for all charges on any professional services rendered.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information necessary to process claims and collect payment for services rendered.

PATIENT / GUARANTOR SIGNATURE: **DATE:**