FORT WORTH PODIATRY

Jon P. McCreary, D.P.M, FACFAS

PATIENT REGISTRATION FORM

Patient Registration Information

*If Patient **cannot** be billed for these services (for example, **minor children)** , please complete **RESPONSIBLE PARTY SECTION** below as well as this patient registration information section.*

Social Security # _____ Driver's License #: _____ State: _____

First Name: _____ MI: _____ Last Name: _____

Preferred Name: _____ Marital Status: S M W D

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: _____

Home Phone: _____ Cell: _____ Other: _____

Work Phone: _____ Email : _____

Perferred Communication: ___Email ___Cell ___Text ___Home Phone ___Portal

Race: _____ Ethnicity: _____ Language: _____

Responsible Party and Billing Information

Responsible party section must be completed

Patient Relationship to Responsible Party: Child Other (specify) _____

Responsible Party SS #: _____ Sex: _____ Date of Birth: _____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Work: _____

Please complete this form in its entirety at your first visit. It is the patient's responsibility to notify our office of any changes to the information listed on this form.

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Primary Insurance

Please complete the information below and provide a copy of the insurance card.

Patient Relationship to insured party: Self Spouse Child Other (Specify) _____

Insurance company: _____

Policy Holder's name: _____

Policy Holder's Date of Birth: _____

Policy Holder's Sex: _____ Policy Holder's Social Security #: _____

Policy Holder's Phone #: _____

Secondary Insurance

Please complete the information below and provide a copy of the insurance card.

Patient Relationship to insured party: Self Spouse Child Other (Specify) _____

Insurance company: _____

Policy Holder's name: _____

Policy Holder's Date of Birth: _____

Policy Holder's Sex: _____ Policy Holder's Social Security #: _____

Policy Holder's Phone #: _____

Referral Information

Who referred you? _____

Primary Care Physician: _____ Phone: _____

Address: _____ Fax: _____

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PATIENT REGISTRATION FORM

Assignment of Benefits/Release of Information/Appointment of Authorized Representative

Fort Worth Podiatry *is committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgment that you have been advised that Fort Worth Podiatry has such a Notice of Privacy Practices.*

I hereby assign, transfer and set over to ***Fort Worth Podiatry*** *, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.*

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint ***Fort Worth Podiatry*** *to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.*

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

Signature: _____ Date: _____

Witness: _____ Date: _____

Please complete this form in its entirety at your first visit. It is the patient's responsibility to notify our office of any changes to the information listed on this form.