PATIENT REGISTRATION with Foot and Ankle Clinic of Spokane/Idaho

Use black ink.

Last Name | **Legal First Name** | **MI**

Physical Address | **City** | **State** | **Zip**

Home Phone (_____) _____- | **Work Phone** (_____) _____- | **Cell Phone** (_____) _____- | **Email**

Date of Birth _____/_____/_____ | **Social Security #** -_____- | **Gender** □ Male □ Female | **Marital Status** □ Single □ Married □ Other

Primary Language | **Race** □ Not Specified □ American Indian □ Asian □ Alaska Native □ Black/African American □ Native Hawaiian □ White | **Ethnicity** □ Not Specified □ Hispanic/Latino □ Not Hispanic/Latino

Employment □ Full-Time □ Part-Time □ Retired □ Unemployed | **Employer Name**

Emergency Contact Name _____ □ Family □ Friend □ Spouse | **Relationship** _____ | **Home Phone** ( ) | **Cell Phone** (_____) _____-

Primary Care Physician/Last Visit Date | **Office Phone /Last visit date** (_____) _____- | **Referred By** □ Friend □ Insurance □ Internet □ Magazine □ Newspaper □ Phone Book □ Referring Dr

Your claim is □ Compensable/Work Related □ Automobile □ Other Liability □ Not Related Work/Auto/Liability

Primary Insurance– copy of card required for claim

Insurance Name | **Eligibility Phone** (_____) _____

Medical Claims Address

Insured Name | **Relationship to Insured** □ Self □ Spouse □ Child

Insured Date of Birth _____/_____/_____ | **Insured Social Security #** -_____-

ID # | **Group #**

Insured Employer Name | **Employer/HR Phone #** (_____) _____-

Secondary Insurance– only when Medicare is 1st or 2nd

Insurance Name | **Eligibility Phone** (_____) _____

Medical Claims Address

Insured Name | **Relationship to Insured** □ Self □ Spouse □ Child

Insured Date of Birth _____/_____/_____ | **Insured Social Security #** -_____-

ID # | **Group #**

Insured Employer Name | **Employer/HR Phone #** (_____) _____-

Privacy Information

Circle phone number and time of day where we can contact/leave you message(s)? Home: AM/PM Work: AM/PM Cell: AM/PM

HIPAA Notice given- I have been given a copy of the Privacy Policies of this facility.

ATTEST: I do hereby attest that this information is true,accurate and complete to the best of my knowledge.

PAYMENT DUE AT TIME OF SERVICE: I agree to pay my unmet deductible, copay and estimated coinsurance today and each visit. I hereby authorize charging my credit card for ☐ all of today's charges including deductible/copay/coinsurances ☐ all future visits' coinsurances Visa/MC Card Number_____Expires_____

_____ Print Name of Patient or Legal Authorized Representative

_____ Signature

_____ Relationship to Patient

_____ Date