METRO FOOT & ANKLE
Daniel Saunders, DPM, FACFAS,

NEW PATIENT REGISTRATION

First Name | Last Name | MI | Date of Birth

Gender M F | SSN | Driver's License | State

Martial Status	Ethnicity	Race (Please circle)	
Married	*Hispanic/ Latino*	*American Indian/ Alaskan Native*	*White*
Single	*Non-Hispanic*	*Asian*	*Other*
Divorced	*Decline*	*Black or African American*	*Decline*
Widowed		*Native Hawaiian/ Other Pacific Islander*	

Preferred Language *English* *Spanish* *Other*_____

Address | Apt | City | State | Zip

Home Phone | Cell Phone | Work Phone | Emergency Contact

E-mail Address_____ Type of Employment_____

INSURANCE INFORMATION (Please a provide copy)

1) Insurance Name | Policy Holder Relationship | 2) Insurance Name | Policy Holder Relationship

GUARANTOR (Please fill out for patients under the age of 18)

First Name | Last Name | MI | Date of Birth

Address | Apt | City | State | Zip

SSN | Phone | Relationship to Patient

PHARMACY/ FAMILY DOCTOR INFORMATION

Family Physician | Office Telephone

Pharmacy Name | Street | City | Telephone

How did you arrive at Metro Foot & Ankle? **Referred by**_____

Yellow Pages / DEX Book Family / Friend Sign Insurance Website / Book Online_____

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize payment of any medical insurance benefits to the above names physician/group. I hereby authorize Metro Foot and Ankle, PC to furnish my insurance carrier(s) any information that they may request in order to process a claim for medical services rendered by a physician of Metro Foot and Ankle, PC. I agree to pay all charges incurred for medical services and understand that I am financially responsible regardless of insurance coverage. I also agree that it is my sole responsibility to provide this office with any changes or updates to my insurance coverage or personal information. I am aware that a copy of HIPPA guideline is available for my review at anytime in the front office. I agree to provide 24hr notice for appointment cancellation to avoid a fee. There is a $25 fee for failing to keep your appointment. I understand that if I fail to make payment for services rendered, my account may be turned over to a collection agency, and a 40% fee will be added to any balance.

Signature_____ Date_____
Self/Guarantor

Financial Policy: Payment is due in full at the time of service to avoid potential finance charges