METRO FOOT & ANKLE
Daniel Saunders, DPM
Jessica Cerda, DPM

PATIENT REGISTRATION

Patient Name:____ Date of Birth: _____/_____/_____ Age: ______
First Middle Last

Social Security No: ________ - ______ - ________ Martial Status (circle): S M D W Sex (circle): Female Male

Address: ____Apt No: _______________

City: ___________________________________ State: __________ Zip: _____________

Home Phone: (_______)_______________ Cell Phone: (_______)_______________

Employer Name:_____________________ Occupation: ________________ Work Phone: (_______)________________

Emergency Contact:_____________________________ Relation:______________ Phone: (_______)________________

INSURANCE INFORMATION (POLICY HOLDER'S INFORMATION)

Primary Insurance:______________________ Secondary Insurance:____________________

Policy Holder Name:____________________ DOB: / / Policy Holder Name:____________________ DOB: / /

Relation To Patient: (circle) Self Spouse Child Parent Relation To Patient: (circle) Self Spouse Child Parent

~~~~~~~~~~~GUARANTOR (PLEASE FILL OUT FOR PATIENTS UNDER THE AGE OF 18)~~~~~~~~~~~

Name______________________________________ Relation to Patient____________ Date of Birth _____/_____/_____

Social Security No ________ - ______ - ________ Home Phone:(_______)_________________

Address ___________________________________Apt No________ City:__________________ State:______ Zip:_________

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Work / Auto Related Injury? (circle) Yes or No Family Doctor:___________________________

How did you arrive at Metro Foot & Ankle? (circle one)
Yellow Pages/DEX Dr's Office Family/Friend Insurance Online Search Sign

Referred By: ____

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize payment of any medical insurance benefits to the above named 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 guidelines is available for my review at any time 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________________

Financial Policy: Payment is due in full at the time of service
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