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
Married
Single
Divorced
Widowed

Ethnicity
Hispanic/ Latino
Non-Hispanic
Decline

Race (Please circle)
American Indian/ Alaskan Native
Asian
Black or African American
Native Hawaiian/ Other Pacific Islander
White
Other
Decline

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