MARTIN FOOT AND ANKLE

ADULT REGISTRATION FORM

717-757-3537 or 1-800-456-0076
www.martinfootandankle.com

Patient Information

Last Name	First Name	M.I.	Home Phone Number ( )	Cell Phone Number ( )

Street Address	City	State	Zip	Date of Birth	Gender ☐ Male ☐ Female

Pharmacy	Email Address	Marital Status: ☐ Legally Separated ☐ Married ☐ Widowed ☐ Annulled ☐ Domestic Partner ☐ Divorced ☐ Never Married

Patient's Employer	Occupation	Work Phone No. ( )

Race (check one which best applies):
☐ White ☐ Asian
☐ Black/African American ☐ Other
☐ American Indian/Alaska Native ☐ Decline/Unknown
☐ Native Hawaiian/other Pacific Islander

Ethnicity:
☐ Spanish/Hispanic Origin
☐ Not of Spanish/Hispanic Origin
☐ Declined/Unknown

Preferred Language (select one):
☐ English ☐ French ☐ Italian ☐ Korean ☐ Chinese ☐ Other _____
☐ Spanish ☐ German ☐ Japanese ☐ Vietnamese ☐ Decline/Unknown

How did you hear about our offices? ☐ Newspaper _____ ☐ Magazine _____
☐ Yellow pages ☐ Billboard ☐ Friend ☐ Referring Physician
☐ Another patient ☐ Internet ☐ Relative Name of Referring physician: _____
☐ Radio ☐ Television ☐ Other _____

Spouse Information (if applicable)

Spouse's Name	Date of Birth

Spouse's Phone # ( )	Spouse's Employer

In Case of Emergency

Name	Phone Number ( )

Family Physician

Name of Family Physician/General Practitioner	Address	Phone Number ( )

I hereby give my permission for all physicians of Martin Foot and Ankle to administer treatment and to perform such procedures as may be necessary for the diagnosis and/or treatment of my foot and/or ankle condition.

_____ _____
Signature of Patient / POA / Responsible Party Date

AUTHORIZATION STATEMENT:

I hereby authorize the processing of the medical insurance either by electronic or manual method of MARTIN FOOT AND ANKLE. My signature below authorizes payment of all major medical and/or surgical benefits to which I am entitled. I further authorize the assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation for payment of any co-insurance or deductible and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as an original.

Payment methods are: Cash, Check or Credit Card (Debit, Visa, MasterCard, Discover, American Express, and Care Credit)

_____ _____
Signature of Patient / POA / Responsible Party Date