DEPENDENT REGISTRATION FORM

For Patients Under their Guardian's Health Insurance

MARTIN FOOT AND ANKLE

717-757-3537 or 1-800-456-0076

www.martinfootandankle.com

Patient Information

Patient's Last Name	First Name	M.I.	Nickname

Street Address	City	State	Zip

Phone Number ( ) ☐ Home ☐ Cell	Gender ☐ Male ☐ Female ☐ Other	Date of Birth	Pharmacy

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

Guardian Information

Last Name of Guardian	First Name	Relationship

Street Address

City	State	Zip

Date of Birth	Phone Number ( )

Email Address

Employer	☐ Insurance Policy Holder

Guardian Information (if second guardian)

Last Name of Guardian	First Name	Relationship

Street Address

City	State	Zip

Date of Birth	Phone Number ( )

Email Address

Employer	☐ Insurance Policy Holder

How did you hear about our offices?
☐ Internet/Social Media
☐ Friend/ Relative
☐ Television
☐ Referring Physician
Name _____
☐ Other _____

In Case of Emergency

Name of nearest friend/relative not living with you in your household	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 dependent's 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 _____