# FAMILY FOOT CLINIC REGISTRATION FORM

**DATE:** _____ **FAMILY PHYSICIAN:** _____
**Physician Phone #:** _____

Patient's Name: _____ Birthdate: _____

Patient Social Security No. _____

Address _____

Tele# _____ Cell# _____

Work# _____ Email Address _____

Pharmacy# _____

## INSURANCE

Primary Insurance _____ Policy# _____
**(if minor, policy holder info)**

Insured's Name _____ DOB _____ SS# _____

Secondary Insurance _____ Policy# _____

Insured's Name _____ DOB _____ SS# _____

**Authorization and Release**

**I authorize release of any information concerning myself (or my child) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance otherwise payable to me directly to the doctor. I will be responsible for any remaining balance that I owe to Family Foot Clinic, OR any cost of court and attorney fees.**

**X** _____ **Date** _____
Signature of patient (or parent if minor)

(434)-447-3395 (434)-447-4979-Fax