

**PATIENT REGISTRATION FORM**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Best Contact #: \_\_\_\_\_ Gender: \_\_\_\_\_  
M/S: single married divorced widowed Email Address: \_\_\_\_\_  
Spouse/Guardian Name: \_\_\_\_\_  
Spouse/Guardian DOB: \_\_\_\_\_ Spouse/Guardian SSN: \_\_\_\_\_  
Spouse/Guradian Employer: \_\_\_\_\_ Employer #: \_\_\_\_\_

-----**EMPLOYER INFORMATION**-----

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
Employer Phone #: \_\_\_\_\_ Is insurance through this employer? YES NO

-----**INSURANCE INFORMATION**-----

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Group#: \_\_\_\_\_ Group #: \_\_\_\_\_  
Group Name: \_\_\_\_\_ Group Name: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

**PLEASE PRESENT YOUR INSURANCE CARD(S) TO THE RECEPTIONIST.**

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Patient's Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_ Shoe Width: \_\_\_\_\_  
Primary Language: \_\_\_\_\_ Race: \_\_\_\_\_  
Please Circle One: **Ethnicity:** Hispanic/Latino **OR** Non-Hispanic/Latino

FAMILY DOCTOR: \_\_\_\_\_ LAST VISIT: \_\_\_\_\_

PHARMACY: \_\_\_\_\_ LOCATION: \_\_\_\_\_ PHONE#: \_\_\_\_\_

If assignment is taken, I authorize my insurance and/or Medicare benefits to be paid directly to Gaston Foot and Ankle Associates, P.A. I authorize release of information acquired in the course of my treatment in order to process claims. I am financially responsible for all services rendered.

**\*\*SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Gaston Foot & Ankle Associates, P.A.**  
**Waiver of Liability Advance Notice**

Medicare, **and all other private insurance companies** do not generally cover routine trimming of corns, calluses, and toenails after the first visit, unless certain medical conditions are diagnosed. (i.e. severe circulatory disorders).  
Medicare, **and all other private insurance companies** may not cover certain services in a period of less than 61 days and also may not cover shoes, orthotic devices, insoles, and certain supplies such as foot strappings, pads, medications, and other miscellaneous supplies, unless certain medical conditions are diagnosed.

**Patient Payment Agreement**

I understand that I am responsible for and will be asked to pay for any non-covered services or supplies at the time of service. I understand that upon my second no showed appointment I will be responsible for a \$25.00 no show fee.

**\*\*SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_