PATIENT REGISTRATION

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent.
Please fill in all blanks, if information does not apply, please write "N/A".

Last Name	First Name	MI
Street Address	**Email:**	Cell Phone #
Zip City	State	Home Phone ( )
Date of Birth	Sex ( )Female ( )Male	SSN #
Marital Status ( )Single ( )Married ( )Other	Student ( )No ( )Yes, ( )Full time ( )Part time	
Driver's License Number	Family Physician's Name	
Emergency Contact	Emergency Phone ( )	
Every Appointment is confirmed Please provide preference: Hm phone □ Cell □ Email □		

Employer Information

Referred to our office by:_____

Employer	Work phone ( )
Employer Address	

Insurance Information

Primary Insurance Co.	Insurance #	
Group #	Insured's Date of Birth	Sex ( )Female ( )Male
Insured	Insured Address	
Insured Employer	Relationship of Patient to Insured	
Do you have a Secondary Insurance? ( )No ( )Yes, complete below information		**_____Initials**
Secondary Insurance Co.	Insurance #	
Group #	Insured's Date of Birth	Sex ( )Female ( )Male
Insured	Insured Address	
Insured Employer	Relationship of Patient to Insured	

Responsible Party (Fill out only if other than the patient)

Last Name	First Name	MI
Street Address		
Zip City	State	Phone ( )
Date of Birth	Sex ( )Female ( )Male	SSN #
Relationship to patient	Employer	Work phone ( )

PAYMENT POLICY:
CANCELLED/RESCHEDULED APPOINTMENTS WITHOUT A 24 HOUR NOTICE WILL BE CHARGED $25.00

All services rendered are the financial responsibility of the patient or the patient's parent or guardian. The patient is responsible for payment regardless of insurance coverage. Billing information will be provided to expedite patient reimbursement from private insurance carriers.

AUTHORIZATION OF PAYMENT AND RELEASE OF MEDICAL RECORD:

I hereby authorize the provider of services to release information concerning my health and/or treatment for insurance purposes and to receive direct payment for benefits payable to me for services rendered. I hereby authorize San Antonio Podiatry Associates PC and/or Endeavor Clinical Trials to request medical records from my physicians/ hospitals for medical treatment.

Signed_____ Date_____
(patient or patient's parent or guardian if minor)