



HUDSON VALLEY FOOT ASSOCIATES

PATIENT REGISTRATION FORM

Patient's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Sex: M F Student: FT PT Maiden Name: \_\_\_\_\_

SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Marital Status: Single Married Divorced Legally Separated Widowed

Employer Name & Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Primary Care Dr. \_\_\_\_\_ Address: \_\_\_\_\_

Referral Source

Dr. \_\_\_\_\_ Patient/ Friend Radio Newspaper Internet Yellow Pages Other: \_\_\_\_\_

Is this visit related to a: Motor Vehicle Accident Work-related Injury Date of Injury: \_\_\_\_\_

INSURANCE AND BILLING INFORMATION

(If same as Patient, leave blank and continue on Line 4.)

1. Person Responsible for Payment: \_\_\_\_\_

2. Responsible Person's SS# : \_\_\_\_\_ Date of Birth: \_\_\_\_\_

3. Responsible Person's Employer: \_\_\_\_\_

4. Insurance Company: \_\_\_\_\_ Co-Pay: \_\_\_\_\_

5. Insured ID#: \_\_\_\_\_ Insurance Effective Date: \_\_\_\_\_

(Complete if applicable.)

6. Group Name: \_\_\_\_\_ Group # : \_\_\_\_\_

(If same as Person Responsible For Payment, leave blank and continue on Line 12.)

7. Insured Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

8. Insured Home Address: \_\_\_\_\_

9. City, State and Zip Code: \_\_\_\_\_

(If same as Patient, leave blank and continue on Line 12.)

10. Insured Date of Birth: \_\_\_\_\_ Insured SS # : \_\_\_\_\_

11. Insured Home Phone: \_\_\_\_\_

12. Patient Relationship to Insured: Self Spouse Dependent

Secondary Insurance Company: \_\_\_\_\_

Insured ID: \_\_\_\_\_ Effective Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Group Name: \_\_\_\_\_ Group # : \_\_\_\_\_

Insured Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_