PATIENT REGISTRATION

Last Name:
First Name: Middle:
Address:
City: St: Zip: -

Home: Work:
Cell: Ext:

Primary Care Dr.:
Address:
City: St: Zip: -
Date of Last Visit: Phone:

SS#:
Preferred Language:

◯ Male
◯ Female

◯ Single
◯ Married
◯ Divorced
◯ Separated
◯ Widowed

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other
☐ Decline

◯ Hispanic or Latino
◯ Not Hispanic or Latino
◯ Decline

Date of Birth: Occupation: **Employer**:
Address:
City: St: Zip: -

☐ I give consent to access my pharmacy records.

Pharmacy:
Address:
City: St: Zip: -
Phone: Fax:

Nearest relative Not Living with you:
Address:
City: St: Zip: -
Relationship: Phone:

Primary Ins. Co.:
Policyholder Name:
Date of Birth: Relationship:

Secondary Ins. Co.:
Policyholder Name:
Date of Birth: Relationship:

Is this an **injury**? ☐ On the job? ☐ Did you report it? ☐ If not on the job, where?

How did you find out about our practice?

☐ Primary Care Physician	☐ Other Doctor:	
☐ Insurance Website	☐ Family/Friend:	
☐ Sign/Drive-By	☐ Internet Website:	
☐ Yellow Pages	☐ Other Source:	

E-Mail:

I understand that I am ultimately responsible for the balance on my account for services rendered. I authorize payment of any medical benefits directly to East Cobb Foot & Ankle Care for services rendered. I authorize the release of any medical information necessary to process any insurance claim. I understand that my e-mail may be used for correspondence with this office.

Patient or Authorized person's signature: _____Date: _____