Four States Foot Clinic Registration Form:

Name: ______________________ Date of Birth: ______________

SS#: ______________ Sex: ______________ Race/Ethnicity: ______________

Address: ______________ City: ______________ State: ______ Zip: ______

Primary Phone: ______________ Secondary Phone: ______________

Home, Cell, Other (circle) Home, Cell, Other (circle)

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Email Address: ______________________

Employer: ______________________ Work Phone: ______________

Address: ______________ City: ______________ State: ______ Zip: ______

Referred By: ______________ Primary Care Physician: ______________

Pharmacy: ______________ Location: ______________

Responsible Party

Name: ______________ Sex: ______________ Date of Birth: ______________

Address: ______________ City: ______________ State: ______ Zip: ______

Home/Cell#: ______________ SS# ______________

Employer: ______________ Work Ph#: ______________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Insurance

Primary Insurance: ______________ Secondary Insurance: ______________

Insured: ______________ Insured: ______________

Address: ______________ Address: ______________

City: ______ State: ______ Zip: ______ City: ______ State: ______ Zip: ______

Insured DOB: ______ SS#: ______ Insured DOB: ______ SS#: ______

Insured ID#: ______________ Insured ID#: ______________

Group#: ______________ Group ______________

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child

Guardian Name (Print)______________________

Patient/Guardian Signature______________________ Date: ______________