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:** _____