Grants Pass Podiatry

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PODIATRIC PHYSICIANS AND SURGEONS
1227 NE 7th St., Ste. A; Grants Pass, OR 97526
Phone: 541-471-3668 Fax: 541-471-4814

PATIENT REGISTRATION

Patient's Name ______________________ Date ________

Date of Birth ______________ Gender ☐ M ☐ F Age ________

Mailing Address ______________ City ________ State ____ Zip ____

Home Phone ______________ Cell Phone ______________

SS# ______________ Email ______________

Race ________ Ethnicity ________ Marital Status ☐ Single ☐ Married

Education ☐ High School ☐ Undergraduate ☐ Masters ☐ Doctorate Field of Study ________

Employment ☐ Employed ☐ Not employed ☐ Full-time student ☐ Part-time student ☐ Retired

Employer Name ______________ Occupation ______________

Employer Address ______________ City ________ Work Phone ________

EMERGENCY CONTACT

Name ______________ Relationship to Patient ______________

Address ______________ City ________ State ____ Zip ____

Home Phone ______________ Cell Phone ______________

INSURANCE

Primary Insurance Company ______________ Phone ________

Policy Holder ______________ Patient's Relationship to Policy Holder ________

Group # ______________ ID # ________ Co-pay? ________

Employer of Policy Holder ______________ Employer Phone ________

Secondary Insurance Company ______________ Phone ________

Policy Holder ______________ Patient's Relationship to Policy Holder ________

Group # ______________ ID # ________ Co-pay? ________

Employer of Policy Holder ______________ Employer Phone ________

SIGNATURE

I agree that the above information is correct to the best of my knowledge, and that I have read and understand all of the Grants Pass Podiatry patient privacy and billing procedures.

Patient Signature ______________ Date ________

OR Signature of Legal Guardian ______________ Date ________