# Grants Pass Podiatry

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PODIATRIC PHYSICIANS AND SURGEONS
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## 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 _____