The Foot Doctor

Paul Baumgarten, DPM

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Wynantskill, NY 12198
518-346-6000

Patient Registration Form

Please complete all sections. Type in the fields or print and write clearly.

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Contact #: _____ ◯ Home ◯ Cell ◯ Work

Secondary Contact #: _____ ◯ Home ◯ Cell ◯ Work

Date of Birth: _____ Sex: ◯ Male ◯ Female Email: _____

Race: _____ Ethnicity: _____ Primary Language: _____

PRIMARY INSURANCE

Insurance Company: _____ ID #: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Patient's Relationship to Subscriber: ◯ Self ◯ Spouse ◯ Dependent

SECONDARY INSURANCE

Insurance Company: _____ ID #: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Patient's Relationship to Subscriber: ◯ Self ◯ Spouse ◯ Dependent

CONTACTS & PHYSICIANS

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Pharmacy: _____ Address: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____

REASON FOR TODAY'S VISIT

Please read and sign:

I understand that my eligibility for coverage by the insurance named above may not be confirmed at this time. I wish to receive medical services and if it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of Information): I authorize the release of medical or other information that may be required to process insurance claims.

The information on my intake form(s) is correct to the best of my knowledge. I understand that I am responsible for notifying the practice of any updates to my demographics and/or medical history.

_____ _____

Signature of Patient / Responsible Party (sign after printing) Date