Northeast Foot and Ankle Clinic
Michael S. Worpell, DPM, FACFAS
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Patient Registration

Last Name: _____ First: _____Middle: _____

How would you like to be addressed? _____ SSN: _____

Date of Birth: _____ Age: _____Marital status: _____

Address:_____

City/State/Zip _____

Home Phone: _____Cell Phone_____ Work Phone: _____

Employer_____May we contact you at work?_____

If child, parent's name: _____Parent's address, if different_____

Spouse's Name: _____ Spouse's work number: _____

Emergency
Contact:_____
Name Phone Relationship

Who referred you? _____

Name of Primary Care Physician	**City**		

Insurance

Primary Ins._____

Subscriber/policy holder name _____

Policy holder social security #/DOB_____

Policy holder relationship to patient_____

Secondary Ins._____

Subscriber/policy holder name_____

Policy holder social security # / DOB_____

Policy holder relationship to patient_____

Financial Policy

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named insurance carrier(s). I understand that not all services are covered and that I may be responsible for a balance. I also understand that **my co-pay is due at time of service.** I permit a copy of this authorization to be used in place of the original. This authorization may be revoked in writing either by me or the above-named carrier at any time. I certify that I represent only myself or individual(s) for whom I am guardian and am not here on behalf of a third party. I authorize treatment by any or all providers and professional staff affiliated with Northeast Foot and Ankle Clinic. I understand that Dr. Worpell is not my primary care provider.

By signing below **I confirm that I have read and understand the financial policy**.

_____ _____
Signature of Patient/Legally Responsible Party Date