## Tennessee Foot & Ankle Specialists, P.C.

# REGISTRATION FORM

|  |
| --- |
| Today’s Date |
| PATIENT INFORMATION |
| Patient’s Last Name | First | M. I.  | SSN | Marital Status (circle one)Single Married Divorced Widowed |
| Home Phone #  | Cell Phone # | Work Phone # | Date of Birth  | Age | Sex ❑ M ❑ F |
| Address | City | State  | Zip Code |
| Email Address |
| Patient Occupation | Employer |
| Responsible Party (If different) | Relationship | Contact Phone # |
| Address (If different) | City | State | Zip Code |
| Primary Care Physician | Date Last Seen | Phone # (If out of area) |
| Address (If out of area) | City | State | Zip Code |
| Referred By |
| Emergency Contact Name | Phone # | Relationship to Patient |

|  |
| --- |
| INSURANCE INFORMATION |
| **PRIMARY INSURANCE CARRIER** |
| Insurance Name | Subscriber ID # | Group # |
| Copayment / Coinsurance$ | Insurance Phone # | Does your insurance require a referral? |
| Insured Name  | Insured Date of Birth | Relationship to Patient |
| **SECONDARY INSURANCE CARRIER** |
| Insurance Name | Subscriber ID # | Group # |
| Copayment / Coinsurance$ | Insurance Phone # | Does your insurance require a referral? |
| Insured Name  | Insured Date of Birth | Relationship to Patient |