

CAPITAL PODIATRY ASSOCIATES CHTD.®

1145 19th STREET, N.W., SUITE 409

WASHINGTON, D.C. 20036

Telephone (202) 223-0500

PATIENT REGISTRATION INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____
Last Name First Name Initial

Address _____ Home Phone _____

City _____ State _____ Zip _____

Sex: M F Minor Single Married Long Term Partner Divorced Widowed Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who referred you to our office? _____

In case of emergency, who should we contact? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE (IF APPLICABLE)

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to _____ all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents.

I authorize the above noted doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____