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| Patient Information | | | | | | | | | | | | | | | | |
| Patient’s Last Name | | | | | | First | | | | | Middle | | | | Salutation  Choose an item. | |
| Street Address | | | | | | | | City | | | | | | | State | Zip Code |
| Home Phone # | | Work Phone # | | | | | | | Cell Phone # | | | | | | Which phone # is best to reach you? | |
| Birth Date | Age | | | Marital Status | | | | | | Gender | | | | Email Address | | |
| Emergency Contact Person | | | | | Relationship | | | | | Phone # | | | | | | |
| Insurance Information – please bring card(s) to our office to be copied | | | | | | | | | | | | | | | | |
| Occupation | | | | | | | Insured Employer | | | | | | **Insured Birth Date** | | | |
| Insured Employer Address | | | | | | | | | | | | | | | | |
| Primary Insurance Company | | | Secondary Insurance Company | | | | | | | | | Patient’s Relationship To Insured | | | | |
| Referred to Dr. Fishco by: | | | | | | | | | | | | | | | | |
| Please specify if applicable:  Please arrive 15 minutes prior to your appointment to complete the registration process. Our receptionist will scan your insurance card and review your forms for completeness. Please review your forms for accuracy. We try very hard to stay on time so that you are not inconvenienced by having to wait to be seen by Dr. Fishco. | | | | | | | | | | | | | | | | |
| Authorization for Assignment of benefits  to William D. Fishco, DPM, PC X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |
| HIPPA Authorization  (Necessary to process claims) X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |