BENENATI FOOT AND ANKLE CARE CENTERS
NEW PATIENT REGISTRATION FORM

PATIENT NAME: _____ SEX _____ AGE_____DATE OF BIRTH _____

Email: _____SS#_____
May we contact you by phone or email for example: appointment reminders or communiqués? YES NO

ADDRESS: _____ CITY: _____ ST: ____ ZIP: _____

HOME PHONE: _____CELL PHONE: _____

EMERGENCY CONTACT NAME: _____ PHONE _____

MARITAL STATUS: _____ EMPLOYER: _____ PHONE: _____ext_____

OCCUPATION: _____

HOW WERE YOU REFERRED TO OUR OFFICE, PLEASE BE SPECIFIC _____

Reason for your visit/is it injury related_____

Injury related-Who is responsible for your bill? _____

FAMILY PHYSICIAN NAME _____MD or DO PHONE _____

FAMILY PHYSICIAN ADDRESS/CITY _____ FAX _____

PHARMACY NAME: _____ CITY _____PHONE _____

INSURANCE INFORMATION:
NAME OF YOUR INSURANCE(S): _____

SUBSCRIBER NAME: _____ DATE OF BIRTH _____

RELATIONSHIP TO INSURED: _____ PERSON RESPONSIBLE FOR BILL _____

SUBSCRIBER EMPLOYER _____ PHONE _____

Have you received a copy of the Notice of Privacy Act (see attached) Yes No

I hereby authorize payment for all services to be paid directly to Anthony V. Benenati, DPM PC. I understand that I am responsible for all deductibles, co-pays and all services not covered by my insurance company. I also authorize Benenati Foot and Ankle Care Centers to release my medical records to the insurance company regarding pre auth or claim payment and other health care providers for coordination of care. I understand that if my insurance requires me to obtain a referral to be seen and I do not obtain one prior to my visit, I will be responsible for all charges. I do consent to having my blood drawn and being tested for Hepatitis and HIV if Doctors and/or staff of Benenati Foot and Ankle Care Centers are exposed to my blood and/or fluids.

SIGNATURE OF PATIENT: _____ DATE _____
AND/OR GUARDIAN/FOSTER (WE DO REQUIRE PROOF OF GUARDIAN/FOSTER CARE GIVER)