MARVEL FOOT & ANKLE CENTERS

REGISTRATION FORM

GENERAL INFORMATION			
First Name	**Middle Name**	**Last Name**	
SSN	**Birth Date**	**Gender** ☐ Male ☐ Female	**Preferred Name**

ADDRESS and PHONE							
Home Address						**Zip code**	
Home Phone	Area code	Number	**Work Phone**	Area code	Number	Extension	
Cellular Phone	Area code	Number	**Preferred Phone** ☐ Home ☐ Work ☐ Cellular				
Preferred method of communication ☐ Phone ☐ Mail ☐ Email			**Email Address:**				
Emergency Contact:			**Phone:**			**Relationship:**	
Primary Care Doctor:			**Last seen:**				

OTHER	
How did you hear about us?	☐ Dr. ☐ Insurance ☐ Internet/Google ☐ Facebook ☐ Friend/Family ☐ Former Patient ☐ Other
Race	**Ethnicity:** ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ Unreported/Refused
Preferred Language ☐ English ☐ Spanish ☐ Other	**Do you need an interpreter?** ☐ Yes ☐ No
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner	
Employment ☐ Full-Time ☐ Part Time ☐ Not Employed	**Employer**

PRIMARY INSURANCE		SECONDARY INSURANCE	
Insurance Plan Name		**Insurance Plan Name**	
Subscriber ID		Subscriber ID	
Insured's Name		Insured's Name	
Date of Birth		Date of Birth	
Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other		Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other	

Guarantor Information (only fill out if patient is under 18 years)			
	***The adult present at the visit is the guarantor**		
Guarantor's Name		Street Address	
Date of Birth		City/Town	
Social Security Number		Zip Code	

ASSIGNMENT OF BENEFITS

- I understand I am financially responsible for all charges and services provided to me, including the balance remaining after payment of potential insurance benefits. I authorize payment of medical insurance benefits to Marvel Foot & Ankle Centers for professional services rendered.
- I authorize the release of any information necessary to process this claim.
- I certify that all the above information is true and correct to the best of my knowledge. I give my permission to the Provider and/or medical staff to administer and perform such procedures deemed necessary in the diagnosis and/or treatment of my podiatric condition(s).

(Digital)Signature of Patient / Legal Guardian/Representative	**Relationship**	**Date**

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