

KneeFootAnkleCenter, PLLC

Patient Registration

Name: _____ Age: _____ Birth Date: ____ / ____ / ____
Last First M
Address: _____ Marital Status: S M D W Sep Sex: M F
City: _____ State: _____ Zip: _____ Home Phone: (____) _____
Employer: _____ Work Phone: (____) _____
Name City
Who referred you to our office? _____ Cell Phone: (____) _____
Reason for Today's visit: _____ SS#: _____
WORK RELATED Yes No **IF WORK RELATED**, please enter your claim# here: _____
Date of Injury or when you first noticed symptoms: ____ / ____ / ____ Cause: _____
Physician you are seeing today: Dr. Rolfe Dr. Takemura Dr. Oseto

Financial and Insurance information

Primary:

Name of insurance company: _____ **Referral Required?** Y N
Policy Holder: _____ Insurance phone # _____
Policy number: _____ Group Number: _____
Date of Birth: ____ / ____ / ____ Employer: _____

Secondary:

Name of insurance company: _____ **Referral Required?** Y N
Policy Holder: _____ Insurance phone # _____
Policy number: _____ Group Number: _____
Date of Birth: ____ / ____ / ____ Employer: _____

PLEASE NOTE: Failure to pay co-pays at the time of service will result in a \$15.00 service charge. _____ (Please initial)

Emergency Contact Information

Name: _____ Home Phone:(____) _____
Relation to patient: _____ Alternate Phone:(____) _____

Release of Benefits and Information

I authorize my insurance benefits be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for processing insurance claims.

SIGNED: _____ RELATIONSHIP: _____ DATE: _____
Signature of Patient (or legally authorized representative) Relation to patient