

# Foot Care of Clifton Park

# Patient Registration Form

Patient Name		Home Phone	
Street Address		Cell Phone	
City, State, Zip		Work Phone	
Place of Employment		Email Address	
Primary Care Physician		Date of Birth	
Primary Care Location		Marital Status	
Date of Last Primary Office Visit		Social Security Number	

Primary Insurance		Primary Policyholder	
Policyholder Date of Birth		Your Relationship to Policyholder	
Policy ID		Group Number	
Secondary Insurance		Secondary Insurance Policyholder	
Policyholder Date of Birth		Your Relationship to Policyholder	
Policy ID		Group Number	

I hereby give permission to Dr. Steven/Mindy Lam of Foot Care of Clifton Park to administer treatment and to perform such procedures as deemed necessary in the diagnosis and/or treatment of my condition. I also hereby assign to the above named physicians all benefits provided by my insurance company policy or policies for medical and surgical care. I understand that I am financially responsible for any balance due on my account that my insurance does not cover.

### Durable Medical Equipment and Products Policy

The products and in-office dispensing are for our patient's convenience. Financial responsibility will be solely on the patient and payments for such services or devices are due upon receipt.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_