## Foot Care of Clifton Park

## Patient Registration Form

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|---|---|---|---|
| **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 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** | |

**Privacy Information Preferences:**

**May we send mail to the address on file?** **Yes** **No**

**May we call the phone numbers on file?** **Yes** **No**

**May we leave voicemail on answering machines?** **Yes** **No**

**Do you have a Power of Attorney?** **Yes** **No** **If yes, please list name and phone number:**

**_____**

**_____**

**Do you have a Health Care Proxy?** **Yes** **No** **If yes, please list name and phone number:_____**

**_____**

I hereby give permission to Dr 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. I also understand that any overdue account balances can incur late fees and/or collection fees.

**SIGNATURE_____** **DATE_____**