

WILLIAMS FOOT CENTER

REGISTRATION (PLEASE PRINT CLEARLY)

Chart # _____

Updated _____

Today's Date: _____

Family Doctor: _____

Doctor Phone: _____

Name: _____

First

MI

Last

Address: _____

Street

City

State

Zip

Home # (_____) _____ Work # (_____) _____ Cell # (_____) _____

Social Security # _____ - _____ - _____ Birthdate: ____/____/____ Age: ____

Sex: Male Female Marital Status: Single Married Widowed Separated Divorced

Employer _____ Business Phone # (_____) _____

Address _____ Occupation _____

INSURANCE INFORMATION

Name of person on Insurance Card (i.e., Self, Spouse, Parent)

Name _____ Relation _____ D.O.B. ____/____/____

Name of **Primary** Insurance Company _____

Subscriber or ID# _____ Group # _____

Name of **Secondary** Insurance Company (If any)* _____

Subscriber or ID# _____ Group # _____

*Secondary Insurance filed for most Medicare patients only.

INSURANCE AUTHORIZATION

I request that payment of authorized benefits be made to me or on my behalf to Dr. Melvin Williams for any services provided to me. I authorize the release of my medical information to either my private insurance carrier, state-funded program, or the Health Care Financing Administration and its agent as needed to determine these benefits or the benefits payable for related services. If "other health insurance" is indicated in item 9 of the HCFA- 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare/Commercial Insurance carrier.

PATIENT SIGNATURE _____ **DATE** ____/____/____