**KBF FOOT AND ANKLE SURGEONS, PA**
**PATIENT REGISTRATION**

Welcome to our office. In order to serve you properly, we will need the following information. (**Please Print**)
All information will be strictly confidential.

| Patient's Name:<br><br>**E-mail Address: (To Access Patient Portal)** | SEX<br>M [ ]<br>F [ ] | Birth Date: | Age: | Marital Status:<br>Single [ ] Married [ ]<br>Widowed [ ] Divorced [ ] |
|---|---|---|---|---|

Primary Language: [ ] English [ ] Spanish [ ] Portuguese [ ] Other

Ethnicity: [ ] Not Hispanic or Latino [ ] Hispanic or Latino [ ] Decline to specify

Race: [ ] American Indian/Alaskan [ ] Asian [ ] Black/African American [ ] Hawaiian [ ] White [ ] Decline to specify

| Residence address: City: State: Zip: | | Patient's Social Security # |
|---|---|---|

| Home Phone: | Cell Phone: | Work Phone: |
|---|---|---|

| Person financially responsible for this account: | Self [ ]<br>Spouse [ ]<br>Parent [ ] | Responsible Party's Birth date: | Responsible Party' Social Security # |
|---|---|---|---|

| Name of Employer: Address: | Business Phone: | Occupation: |
|---|---|---|

| Medicare Yes [ ] No [ ] | Medicare # | Workers' Compensation? Yes [ ] No [ ] If Yes-put W/C or MVA carrier below | Motor Vehicle? Yes [ ] No [ ] | Date of Accident: |
|---|---|---|---|---|

| **Primary** insurance company: Address: | Is insurance through your employer? |
|---|---|

| Subscriber Name: | Subscriber birth date: | Policy # | Group # |
|---|---|---|---|
| Name of Spouse/ Domestic Partner: | Spouse's birth date: | Spouse's social security # | Spouse's business phone: |

| Is there secondary ins., Yes [ ] Spouse 2nd carrier, etc.? No [ ] | Name of Spouse's employer: Address: |
|---|---|

| **Secondary** insurance name: Address: | Policy # | Group # |
|---|---|---|

| In case of emergency who should be notified? | Relationship | Phone |
|---|---|---|

**Private Insurance Authorization for Assignment of Benefits/Information Release:**
I, the undersigned authorize payment of medical benefits to KBF Foot and Ankle Surgeons, PA for any services furnished me by the physicians. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent, information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____
Patient, Parent or Guardian Signature (if child is under 18 years old) Date

**Medicare Lifetime Signature on File:**
I request that payment of authorized Medicare benefits be made on my behalf to KBF Foot and Ankle Surgeons, PA for any services furnished me by the physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

_____ _____
Patient Signature Date