Family Footcare, PC

Milton Stern, DPM - Randy Kaplan, DPM - Cindy Pavicic, DPM

Patient Registration

Date: _____

Name: _____

Address: _____

City: _____

State: _____ Zipcode: _____

Date of Birth: _____

SSN: _____

Home Phone: _____

Cell Phone: _____

E-Mail: (Very important to us)

_____

How did you hear about us?

_____

Marital Status: _____

Gender: M F

Employer Name: _____

Work Phone: _____

Family Physician: _____

Phone: _____

Diabetic Physician (if you have one) _____

Phone: _____

Use this section if insurance is in patient's name.

Primary Insurance: _____

Insurance Numbers: _____

Secondary Insurance: _____

Insurance Numbers: _____

Use this section if insurance is in someone elses name.

Primary Insurance: _____

Insurance Numbers: _____

Secondary Insurance: _____

Insurance Numbers: _____

Insured relationship to patient: ☐ Spouse ☐ Child ☐ Parent Other: _____

Insurance Verification: **Office Use: Do not fill out**

Is insurance active? Y N Co-pay: _____ Encounter Fee: _____ Deductible: _____

Is referral needed? Y N Do we have one? Y N Orthotics covered? Y N

Any restrictions to foot care? _____

Verified by: TM CM Other: _____ Date: _____

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