FOOT HEALTH CENTER

Dr. Thomas H. Walter, DPM

PATIENT REGISTRATION FORM

☐ Male

☐ Female

Patient Name: Last First M.I.

By what name do you prefer to be addressed?

Patient Address

City State Zip

Home Phone Work Phone Cell Phone

Emergency Contact Phone

Birthdate Social Security Number

Employer

Who may we thank for referring you?

Primary Care Physician Phone Date Last Seen

Primary Insurance ID # Group #

Insured's Name

Secondary Insurance ID # Group #

We are required to have a copy of your insurance cards on file in order to bill your insurance for you. If we do not have this information you will be billed directly and are solely responsible for all charges. Payment is due at time of service. If you submit your insurance card at a later date we will be glad to bill your insurance company and reimburse you when payment is received.

Release of Benefits Information:
I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible for all co-payments, deductibles and non-covered services. I authorize the release of information required to process my claims. (If not signed, payment is due at time of service.) **ALL CO-PAYMENTS DUE ON DAY OF SERVICE.**

I hereby give my consent for **THOMAS H. WALTER, DPM** to examine and render treatment.

Patient's Signature Date