(Please Print)

REGISTRATION FORM

Today's Date ____/____/____ Facility ______________________ Doctor ________________

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Mrs. ☐ Dr. ☐ Miss	☐ Sr. ☐ Jr.

Street Address	City	State	Zip Code

Home Phone #	Work Phone #	E-mail Address
( ) -	( ) -	

Birth Date	Age	Social Security Number	Marital Status	Sex
/ /			☐Single ☐Mar ☐Widow ☐Div	☐ M ☐ F

INSURANCE INFORMATION

Occupation	Insured Employer

Insured Employer Address

Please indicate primary insurance	Address of primary insurance carrier	Phone number
		( ) -

Insured Name	Insured S. S. #	Insured ID	Policy Group #	Eff. Date	Co-Payment
					$

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other **Insured Birth Date** / /

Insurance Type ☐ PPO ☐ EPO ☐ HMO ☐ POS ☐ Self Pay ☐ Medicare ☐ Public Aid ☐ WC ☐ OTHER ____________.

Please indicate secondary insurance	Address of secondary insurance carrier	Phone number
		( ) -

Insured Name	Insured S. S. #	Insured ID	Policy Group #	Eff. Date	Co-Payment
					$

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other **Insured Birth Date** / /

Insurance Type ☐ PPO ☐ EPO ☐ HMO ☐ POS ☐ Self Pay ☐ Medicare ☐ Public Aid ☐ WC ☐ OTHER ____________.

Referred to Institute by (Please use one)		**Address**
☐ Doctor	______________	______________
☐ Hospital	______________	______________
☐ Insurance Plan	______________	______________
☐ Family	______________	______________
☐ Friend	______________	______________

☐ Tribune ☐ Herald ☐ Sun Times ☐ T.V ☐ Radio ☐ Other ______________________

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
To Weil Foot & Ankle Institute, Ltd.

X ______________________ / /
Signature Date

HIPAA AUTHORIZATION
Necessary to process claims

X ______________________ / /
Signature Date

COMMUNICATION AUTHORIZATION
I authorize Weil Foot & Ankle Institute to contact me via phone, text, fax, mail and email

X ______________________ / /
Signature Date