



FOOT & ANKLE INSTITUTE

(Please Print)

REGISTRATION FORM

Today's Date ___/___/___ Facility _____ Doctor _____

PATIENT INFORMATION

Patient's Last Name	First	Middle	Birth Date / /
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DEMOGRAPHICS (FOR GOVERNMENTAL STATISTICAL ANALYSIS)

Race American Indian or Alaska Native Asian Native Hawaiian Black or African American White Hispanic Other Pacific Islander Other Race I Decline to Report

Ethnicity Hispanic Non-Hispanic I Decline to Report

Preferred Language English Spanish Other _____

PHARMACY / PRESCRIPTION INFORMATION

Preferred Pharmacy:

Costco CVS Osco Target Wal-Mart Walgreens Other _____

Address or Cross-Streets: _____

City: _____

State: __

Zip Code: _____

Phone Number: _____

Fax Number: _____

This is a mailorder pharmacy

I do not have a preferred pharmacy

I authorize Weil Foot & Ankle Institute and its affiliated providers to view my external prescription history via the Surescripts service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

To Weil Foot & Ankle Institute, Ltd.

X

Signature

/ /

Date