



Mercado Foot & Ankle Center

Registration Form

Today's Date:			
PATIENT INFORMATION			
Patient's Last Name:		First:	Middle:
			Marital Status (circle one) Single / Married / Other
Age:	Birth date:	Social Security:	Home Phone:
Street Address:		Gender: Male or Female	Cell Phone:
City:	State:	ZIP Code:	Employer: Address:
Occupation:	Primary Care Phys:		Address:
Phone:	Phone:		
In Case of Emergency:	Phone:		Relationship:
How did you hear of our office?			

INSURANCE INFORMATION			
Patient Relationship to Subscriber:	Self	Spouse	Child
Subscriber's Name:	DOB:	Address:	Home Phone:
Subscriber's Social Security Number:			

I have reviewed a copy of the Mercado Foot & Ankle Center's Notice of Privacy Practices. At my request I can receive a copy of the Notice of Privacy Practices. _____ (please initial)

MY SIGNATURE BELOW AUTHORIZES AND AGREES TO THE FOLLOWING:

The above information is true to the best of my knowledge I HAVE NO OTHER INSURANCE COVERAGE OTHER THAN WHAT IS INDICATED ABOVE. I authorize my insurance benefits to be paid directly to the physician. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CO-PAYMENTS, DEDUCTIBLES, CO-INSURANCE, AND ANY AND ALL NON-COVERED SERVICES FOR MYSELF OR DEPENDENT(S) WHEN SERVICES ARE RENDERED. I also authorize MERCADO FOOT & ANKLE CENTER to release any information required to process claims. I UNDERSTAND THAT IF I HAVE AN HMO TYPE POLICY IT IS MY RESPONSIBILITY TO MAKE SURE I HAVE PROPER AUTHORIZATION FROM MY PRIMARY CARE PHYSICIAN WHEN NECESSARY. Payment may be made to our office with a valid Visa, MasterCard, Discover, Cash, Money Order, or Check (with a current state issued ID card). A fee of \$30.00 will be assessed to your account for any returned checks and a fee of 35% will be assessed to your account for accounts turned over to collections.

PATIENT/LEGAL GUARDIAN SIGNATURE: _____ DATE: _____