Burlington County Podiatry Associates

Dr. Harris L. Klear

PATIENT REGISTRATION

Welcome to our office. In order to serve you properly, we will need the following information. **(Please Print)**
All information will be strictly confidential.

Patient's Name	Sex M [ ] F [ ]	Birth Date Age_____	Marital Status Single **[ ]** Married **[ ]** Widowed [ ] Divorced [ ]
Residence address City State Zip		Home Phone:	Patient's Social Security #
Cell phone	Email		
Person financially responsible for this account	Self Spouse Parent	Responsible Party's Birthdate	Responsible Party's Social Security #
Name of employer Address		Business Phone	Occupation
Name of Spouse/Parent	Birth date	Social security #	Business phone
Reason for Visit:	Referred by: (include address and phone)		
Person to contact in case of emergency:	Relationship to patient	Phone	

Medicare Yes [ ] No **[ ]**	Medicare #	Medicaid Yes **[ ]** No **[ ]**	Medicaid #	Effective Date
Medicare Secondary insurance name Address			Policy #	Group #

Workers' Compensation? Yes **[ ]** No **[ ]** Motor Vehicle? Yes **[ ]** No **[ ]** **If Yes-put W/C or MVA carrier below**	Date of Accident	Treatment authorized by	Claim #	W/C or MVA Insurance Phone #
Primary insurance company Address				Is insurance through your employer?
Subscriber Name	Subscriber birth date	Policy #		Group #
Secondary insurance name Address			Policy #	Group #

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Practice Name for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services

_____ _____
Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Practice Name for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. I understand that I am responsiblef or any and all collection costs, late charges, collection fees, interest charges, and legal and court fees.

_____ _____
Patient, Parent or Guardian Signature (if child is under 18 years old) Date