

MAXFOOTCARE.COM
Centers For Foot Disorders
Max S. Ribald, DPM

Patient Registration

Thank you for choosing our office to serve you properly, we need the following information. Please print. All information will be confidential.

Patient Name _____ Date _____ Marital Status S M W Sep D Age _____
SSN _____ Male/Female Birth date _____ Home Phone _____
Address _____ Extra Phone# _____
City _____ State _____ Zip _____
Emergency contact _____ Tel# _____ Relationship _____

PATIENT Employer Information

Employer name _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Patient's Occupation _____
How did you hear about us? () Phonebook/YP () Ins. _____ () Primary Dr. _____
() Other _____ () Internet _____

PLEASE INCLUDE INFORMATION ON PERSON WHO THE INSURANCE IS THROUGH (if not the patient)

Name _____ Telephone # _____
Address _____ City _____ State _____ Zip _____
Relationship to patient _____ Date of Birth _____ SS# _____
Is This Person Currently a Patient in Our Office? Yes/No

SECONDARY INSURANCE

Name Of Insured _____ Relationship To Patient _____
Birth date _____ Social Security Number _____

Authorization & Release

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand I am responsible for payment of the annual deductible and co-insurance. I am also responsible for payment of any non-covered services or services determined by my insurance not to be medically necessary.

X _____ Date _____
Signature of patient (or parent if minor)

No Insurance Authorization

I choose not to use authorization and release to insurance due to the lack of insurance. I am responsible for payment in full or by payment plan for all services rendered by Dr. Max S. Ribald, D.P.M. I also understand that if I choose the payment plan that **HALF OR MORE OF MY TOTAL CHARGES ARE DUE WHEN SERVICES ARE RENDERED.**

X _____ Date _____
Signature of patient (or parent if minor)