

Advanced Podiatry of Hampton Roads

Patient Registration (Please Print)

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Social Security Number: _____

Circle One: SINGLE DIVORCED WIDOWED MARRIED (Spouse Name: _____)

Gender: Male Female REFERRED BY: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred Contact #? **HOME CELL WORK**
*When calling regarding your appointment, condition, or medical information:
May we leave a message on your answering machine? YES NO
May we leave a message with anyone who answers the telephone YES NO*

Email: _____

Emergency Contact Name/Relationship: _____ Phone: _____

Employer Name: _____

Complete Address: _____

-----**Insurance Information**-----

Primary Care Provider (PCP/FAMILY DOCTOR) Name: _____ Phone: _____

Primary Insurance: _____ Phone: _____

Policy#: _____ Group#: _____ Effective Date: _____

Policy Holder Name/Relationship: _____ Policy Holder SSN#: _____

Secondary Insurance: _____ Phone: _____

Policy#: _____ Group#: _____ Effective Date: _____

Policy Holder Name/Relationship: _____ Policy Holder SSN#: _____

I hereby consent and give my permission to **Dr. Rex Diaz, Advanced Podiatry of Hampton Roads** (the doctor's assistant or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

I request that all insurance benefits, if any, be assigned directly to **Dr. Rex Diaz, Advanced Podiatry of Hampton Roads**. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of Beneficiary: _____ Date: _____

Printed Name of Beneficiary: _____ Relationship to Patient: _____