

**Fisher Foot & Ankle**

1124 North Tennessee St, Ste 104 Cartersville, GA 30120  
phone: 770-386-4111 fax: 770-386-4905 fisherfoot.com

**Patient Registration Form**

Patient name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex: M\_\_\_ F\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Preferred contact phone #: \_\_\_\_\_ Alternative phone #: \_\_\_\_\_

E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital status: \_\_\_\_\_ Pharmacy: \_\_\_\_\_

Family doctor: \_\_\_\_\_ Date of last visit with family doctor: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Who is responsible for this account? self\_\_\_ parent \_\_\_ guardian \_\_\_ spouse \_\_\_

Date of birth of responsible party (if not self): \_\_\_\_\_

**Emergency contact**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

You may share my information (lab results, appointment info, etc.) with:

_____	_____	(____) _____
Name	relationship	phone number

I understand that payment of all medical care is due at the time of service. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that I am responsible for any costs incurred in the collection of patient's account in case of default, including reasonable attorney fees and court costs.

I grant permission to Fisher Foot & Ankle to release any pertinent information to my insurance company upon request, and I authorize payment directly to Fisher Foot & Ankle. A copy of this authorization shall be considered as effective and valid as the original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_