

Fisher Foot & Ankle

1010 North Tennessee St, Ste 114 Cartersville, GA 30120
phone: 770-386-4111 fax: 770-386-4905 fisherfoot.com

Patient Registration Form

Patient Name: _____

Date of Birth: _____ SSN: _____

Address: _____

City: _____ State: ___ Zip: _____

Home phone: (____) _____ Work phone: (____) _____

Cell phone: (____) _____ E-mail: _____

Sex: M___ F___ Occupation: _____ Employer: _____

Marital status: _____ Pharmacy: _____

Family doctor: _____ Date of last visit with family doctor: _____

Who is responsible for this account? self___ parent ___ guardian ___ spouse ___

Date of Birth of responsible party: _____

SSN of responsible party: _____

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: _____