MORGAN HILL FOOT AND ANKLE CENTER
16360 MONTEREY ROAD SUITE 270
MORGAN HILL CA 95037
PATIENT REGISTRATION

Today's Date:	Primary Care Physician:

PATIENT INFORMATION

Patient's Last Name: First Name: Middle: Marital Status:

Birth Date:	Age:	Sex:	Address(NO PO BOX):

Social Security Number:	Home Phone Number: May We Leave a Message? YES / NO	Cell Phone Number: May We Leave a Message? YES / NO
Occupation:	Employer:	Email Address:

How did you hear about us? / Who were you referred by?:

Other family members seen here:

Primary Language: Race: Ethnicity:

Do you have a legal guardian or healthcare power of attorney? YES / NO (If YES please provide the name / relationship and phone number for this person below)

Pharmacy (Location / Phone Number):

Is there a family member or other person you would like for us to share your medical information with? YES/ NO (If YES please provide the name / relationship / phone number for this person)

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person Responsible for Bill:	Birth Date:	Address (if different):	Home Phone Number:
Occupation:	Employer:	Employer Address:	Employer Phone Number:

Please indicate primary insurance:

Subscriber's Name:	Subscriber's S.S. Number:	Subscribers DOB:	Group Number:	Policy Number:	Specialist Co-payment: $

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's Name and SSN:	Group Number:	Policy Number:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone Number:	Work Phone Number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Morgan Hill Foot and Ankle Center or insurance company to release any information required to process my claims.

Patient/Guardian signature Date