Pasadena Podiatry Group, A.P.C
FOOT DOCTOR USA
Joseph T. Ferrante, D.P.M.
65 North Madison Avenue, Suite 512, Pasadena CA 91101
Telephone: 626-577-0700 Fax: 626-796-3989

PATIENT REGISTRATION

NAME: _____
LAST FIRST MIDDLE INITIAL DATE OF BIRTH

ADDRESS: _____
STREET APT NO. /UNIT NO. /BUILDING NO.

_____ **SOCIAL SECURITY NO.**_____
CITY ZIP CODE

CELL PHONE. _____**RESIDENCE PHONE**. _____

WORK PHONE. _____**MOTHER'S MAIDEN NAME (IF MINOR)** _____

AGE: _____ **MARITAL STATUS**: Married Single Divorced Separated Widowed **SEX**: MALE_____ FEMALE_____

EMPLOYER: _____ **OCCUPATION:** _____

EMPLOYER'S ADDRESS: _____

HOW DID YOU HEAR ABOUT DR. FERRANTE: _____
AT&T YELLOW PAGES___CLARKE YELLOW BOOK___VERIZON BOOK___INTERNET: GOOGLE_____
YELP___ YAHOO___INSURANCE PROVIDERS___OTHER_____

REFERRED BY: _____ PHONE NO._____

PRIMARY CARE PHYSICIAN: _____ PHONE NO._____

EMERGENCY CONTACT: _____ PHONE NO._____

INSURANCE INFORMATION: PPO MEDICARE POS HMO CASH

PRIMARY INSURANCE_____ SECONDARY INSURANCE_____

NAME OF PRIMARY INSURED_____ NAME OF PRIMARY INSURED_____

DATE OF BIRTH_____DATE OF BIRTH_____

INSURED'S I.D. NO._____INSURED'S I.D. NO._____

I request payment of authorized benefits be made to Pasadena Podiatry Group A.P.C./Joseph T. Ferrante, D.P.M. for services furnished me. I authorize any holder of medical information about me to release to any insurance company any information needed to determine these benefits or the benefits payable to related services. **I understand that when notified by physician/supplier that Medicare/my insurance may deny payment for certain services, I agree to be personally and financially responsible for payment.**

I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR NON-COVERED SERVICES, COPAYMENTS, AND DEDUCTIBLES.

_____ _____
SIGNATURE DATE

_____
SIGNATURE OF PARENT/GUARDIAN IF PATIENT IS A MINOR OR UNABLE TO SIGN