JOHN E. LACO, D.P.M., P.A.
LAKEVILLE & DAKOTA FOOT CLINICS

PATIENT REGISTRATION

____
Last Name First MI Sex

____
Address Apt #

____
City State Zip

_______________ ______ _________________
Birth Date Age Social Security #

(______)______________ (______)______________
Home Phone # Work Phone #

(______)______________
Cell Phone #

POLICY HOLDER/RESPONSIBLE PARTY
(if other than patient: parent/guardian or spouse)

____
Last Name First

____
Address

____
City State Zip

__________________ ____________________________
Birth Date Social Security #

(______)______________ (______)___________________
Home Phone # Work Phone #

(______)______________
Cell Phone #

Is what you are being seen for **work related?** YES _______ NO _______

Whom may we thank for referring you? Referring Doctor ___________________________________ Clinic ________________________
Insurance Provider Book ___________ Yellow Pages __________ Which Phone Book _____________________ Other _______________

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Consent to Treat: I hereby authorize John E. Laco, D.P.M., of the Lakeville & Dakota Foot Clinics to administer such treatment as deemed necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment.

Financial Responsibility: I agree that I am financially responsible for all charges for services rendered. I agree to pay all charges which are not covered by insurance or which are not promptly paid by the insurer. I understand and agree it is my responsibility to obtain prior approval required by my insurance company and to take all other steps to qualify for insurance coverage.

Assignment of Benefits: I hereby assign to John E. Laco, D.P.M., P.A., all insurance coverage or other benefits available under any government program, and insurance policy or plan, and any other benefits program, and I direct that all benefits be paid directly to John E. Laco, D.P.M., P.A.

Release of Information: I authorize John E. Laco, D.P.M. to release all medical information, via facsimile or mail, including any information relating to treatment for mental health, alcohol or drug abuse, and or HIV/AIDS related information, required by my insurance company or Worker's Compensation carrier or designee to file for medical benefits. Additionally, John E. Laco, D.P.M. may release information, via facsimile or mail, to any hospital or physician I may be referred from, or referred to, by John E. Laco, D.P.M.

____ ____
Patient Signature Date Parent/Guardian Signature Date

Medicare Statement (if applicable): I request that payment of authorized Medicare benefits be made on my behalf to John E. Laco, D.P.M., P.A., for any services furnished to me. I authorize any holder of medical information about me to release to __________________________ (name of Medicare insurance carrier) any information needed to determine these benefits or the benefits payable for related services.

____ ____
Patient Signature Date Parent/Guardian Signature Date

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Witness Date