Aurora Foot & Ankle Surgical Specialists, LLC

Manx D Quayle, DPM
David Huntsman, DPM

Registration Form

Patient's Legal Name _____ **SS#**_____ Birthdate_____
First MI Last

Is patient minor ***yes*** ___ ***no*** ___ ***if so, name of RESPONSIBLE PARTY/GUARANTOR*** _____

Mailing Address _____
CITY STATE ZIP

Preferred Phone ( )_____ **Message Phone** ( ) _____

Gender: *M – F* **Marital Status***: Married Single Other* **Preferred Pharmacy:**_____

Employer/School: _____**Business Phone** ( )_____

How did you hear about us or who referred you to our office?_____

Race "Census Bureau Categorization" *(Please Circle)* Caucasian/White African American/ Black Chinese Japanese Korean Other Asian American Indian/Alaskan Native Vietnamese Black Hispanic/Latino White Hispanic/Latino Hawaiian/Pacific-Islander Filipino *Refuse

Language Preference if other than English:_____

*****Emergency Contact Name***: _____ **Relationship** _____ **Phone** _____

#1 PRIMARY INSURANCE INFORMATION: **********

Insurance Company Name_____Employer:_____

Primary Policy Holders Name _____ SS# _____ DOB _____

Phone Number Of Policy Holder_____ Address Of Policy Holder_____

 # 2 SECONDARY INSURANCE INFORMATION: **********

Insurance Company Name _____Employer:_____

Primary Policy Holder Name _____ SS# _____ DOB _____

Phone Number Of Policy Holder_____ Address Of Policy Holder_____

WORKERS COMP or MOTOR VEHICLE INSURANCE INFORMATION **********

Insurance Company Name _____ Phone ( ) _____

Claim # _____ Date of Injury _____ Body Part Injured _____

Adjustor Name _____

****

I understand that if insurance information is provided, my insurance will be billed as a courtesy. I am responsible for my portion of the bill at the time that services are rendered, as well as any remaining balance my insurance company does not cover. I further authorize release of any information necessary to my insurance company to aid in the payment of claims.

I, the undersigned hereby authorize Manx D. Quayle, DPM and Associates to examine me, (Or my Minor Son/Daughter) to administer such treatment as is necessary and to perform such procedures as are considered therapeutically or diagnostically necessary.

****Patient/Guardian Signature**_____ **Date** _____