Paul D. Brooks, D.P.M., P.A.

REGISTRATION INFORMATION

Welcome to our office. In order to serve you properly, we will need the following information. All information will be strictly confidential.

Patient's Name	Date of Birth	Gender	Marital Status
Residence address	City	State	Zip

Home Phone:	Work Phone:	Mobile Phone:	Patient's Social Security #

Email Address:	Okay to contact you by email?

Permanent address: (For Snowbirds)	City:	State:	Zip:	Phone:

Reason for Visit:	How did you hear about our office?:

Person to contact in case of emergency:	Relationship to patient	Phone

Primary insurance company	Address		
Subscriber Name	Subscriber birth date	Policy #	Group #
Secondary insurance name	Address		
Subscriber Name	Subscriber birth date	Policy #	Group #
Tertiary insurance name	Address		
Subscriber Name	Subscriber birth date	Policy #	Group #

Medicare Lifetime Signature on File: (For Medicare Beneficiaries only)

I request that payment of authorized Medicare benefits be made on my behalf to **Paul D. Brooks DPM, PA** for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services

_______________________________________ _______________________
Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release/Financial Agreement:

I, the undersigned authorize payment of medical benefits to the **Paul D. Brooks DPM, PA** for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I understand that failure to cancel appointments within 24 hours of appointment will result in a fee of **$25.00** per occurrence. I further understand that any returned checks will be assessed a fee of **$35.00**. I futher understand and agree, that if I fail to make payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney fees. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_______________________________________ _______________________
Patient Signature Date