

# Welcome!

to the office of

**Ernest L. Isaacson, D.P.M.**

## REGISTRATION FORM

(Please Print)

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### PATIENT INFORMATION

|  |                                  |   |                                       |   |   |  |
|--|----------------------------------|---|---------------------------------------|---|---|--|
| Patient's Last Name  |                                  | First                                       | Middle                                | <input type="checkbox"/> Mr. <input type="checkbox"/> Dr.<br><input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. | Marital Status (Circle One)<br>Single / Mar / Div / Sep / Wid |  |
| Is this your legal name?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | If not, what is your legal name? | (Former Name)                               |                                       | Birth Date<br>/ /   | Age   | Sex<br><input type="checkbox"/> M <input type="checkbox"/> F |
| Street Address   |                                  |   | Social Security                       |   | Home Phone No.<br>( )   |  |
| City   |                                  | State                                       | ZIP Code                              |   | Cell Phone No.<br>( )   |  |
| Occupation   | Employer                         |   |                                       | Work Phone No.<br>( )   |   |  |
| Chose Office Because/Referred to by (Please check one box)                           |                                  |   |                                       | <input type="checkbox"/> Dr.  | <input type="checkbox"/> Insurance Plan                       | <input type="checkbox"/> Hospital                            |
| <input type="checkbox"/> Family  | <input type="checkbox"/> Friend  | <input type="checkbox"/> Close to Home/Work | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Other  |   |  |
| Name, address of Primary Doctor:<br>_____  |                                  |   |                                       |   |   |  |

### INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

|  |  |                                   |  |  |                  |
|--|--|-----------------------------------|--|--|------------------|
| Person Responsible for Bill  | Birth Date<br>/ /  | Address (if different)            |  | Home Phone No.<br>( )                  |                  |
| Is this person a patient here?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                   |  |  |                  |
| Occupation   | Employer   | Employer Address                  |  | Employer Phone No.<br>( )              |                  |
| Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |                                   |  |  |                  |
| Please indicate primary insurance  |  |                                   |  |  |                  |
| <input type="checkbox"/> Medicare  | <input type="checkbox"/> Oxford                          | <input type="checkbox"/> GHI      | <input type="checkbox"/> BC/BS                           | <input type="checkbox"/> United Health |                  |
| <input type="checkbox"/> Aetna   | <input type="checkbox"/> Cigna                           | <input type="checkbox"/> Medicaid | <input type="checkbox"/> Local Union<br>(Please specify) | <input type="checkbox"/> Other _____   |                  |
| Subscriber's Name  | Subscriber's S.S. #                                      | Birth Date<br>/ /                 | Group #  | Policy #                               | Co-Payment<br>\$ |
| Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____ |  |                                   |  |  |                  |
| Name of Secondary Insurance (if applicable)  |  |                                   | Subscriber's Name  | Group #                                | Policy #         |
| Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____ |  |                                   |  |  |                  |

### IN CASE OF EMERGENCY

|   |                         |                       |                       |
|---|-------------------------|-----------------------|-----------------------|
| Name of Local Friend or Relative (not living at same address) | Relationship to Patient | Home Phone No.<br>( ) | Work Phone No.<br>( ) |
|---|-------------------------|-----------------------|-----------------------|

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 Dr. Isaacson or insurance company to release any information required to process my claims. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and treatment of my foot problem.

X

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE