Cumberland Valley Foot and Ankle Specialists

REGISTRATION FORM

cumberlandvalleyfootandankle.com
717-763-9581 (fax)
717-761-3161

Patient Information

Last Name **First Name** **M.I.** Date of Birth Gender: □Male □Female

Home Phone: Cell Phone: Street Address City State Zip

Pregnant: □Yes □No Social Security No. Email:

Marital Status: □Single □Married □Domestic Partner □Separated Country: Preferred Language:
□Divorced □Widowed

Race (check one): □Asian/Indian □American Indian/Alaska Native **Hearing Impaired:**
□Black/African American □Hispanic/Latino □White □Yes
□Decline/Unknown □Other □No

Employer: Work Phone: Employment Status:
□Employed □Unemployed □Full-Time Student
Occupation: □Part-Time Student □Retired □Child □Other

Preferred Contact Preference and Messages To Be Left: **Written Contact Preference:**
□Home □Cell □Work □Postal Mail □Email

Spouse Information

Name **Date of Birth** **Employer** **Work Phone:**
Cell Phone:

Guarantor Information

Name:
Relationship:
Address:
Date of Birth: **Home No.:**
Email
Employer **Work No.:**

Guardian Information

Name:
Relationship:
Address:
Date of Birth: **Home No.:**
Email
Employer **Work No.:**

Emergency Contact

Name: **Relationship:** **Phone No.:**

Physician/Pharmacy Information

Primary Care Physician/Location: **Phone No.:**
Referring Physician/Location: **Phone No.:**
Preferred Pharmacy/Location: **Phone No.:**

I hereby give my permission for all physicians of Cumberland Valley Foot and Ankle Specialists, P.C. to administer treatment and to perform such procedures as may be necessary for the diagnosis and/or treatment of my foot and/or ankle condition.

_____ _____
Signature of Patient/POA/Responsible Party Date

Authorization Statement:

I hereby authorize the processing of the medical insurance either by electronic or manual method of Cumberland Valley Foot and Ankle Specialists, P.C. My signature below authorizes payment of all major medical and/or surgical benefits to which I am entitled. I further authorize the assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation for payment of any co-insurance or deductible and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as an original.

_____ _____
Signature of Patient/POA/Responsible Party Date