



Account #

Patient Registration

Name _____ SS# _____ - _____ - _____

Street Address _____ Date of Birth _____ / _____ / _____ Marital Status S M W Sep D

Apartment# _____ City _____ State _____ Zip _____

Telephone: Home _____ Office _____ Cellular _____

How did you find out about our office? _____ E-Mail _____

Spouse's Name _____

Spouse's Employer/Address _____

Emergency Contact _____ Telephone# _____ Relationship _____

Patient Employer Information

Employer name _____ Tel# _____

Street Address _____ City/State _____ Zip _____

Patient's occupation _____

Insured Person (If Not Patient)

Name _____ Date of Birth _____ / _____ / _____

Street Address _____ City/State _____ Zip _____

Telephone# _____ Relationship to Patient _____

Insurance

Medicare# _____ Medicaid# _____

Primary Insurance Company Name _____ Insured Person _____

ID# _____ Group# _____ Telephone# _____

Secondary Insurance Company Name _____ Insured Person _____

ID# _____ Group# _____ Telephone# _____

Medical Information Release and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date _____ Signature _____

- I hereby authorize Dr. Craig Herman, D.P.M. to apply for benefits on my behalf for covered services rendered by him, or by his order. I request that payment from my insurance company be made directly to Dr. Craig Herman, D.P.M. (or to the party who accepts assignment).
- I certify that the information I have reported with regard to my insurance coverage is correct.
- I understand that I will be responsible for any fees deemed to be "patient responsibility" by my insurance company.
- I understand and agree to pay charged fees for service as issued by Dr. Herman's office if I am uninsured or my insurance is inactive.
- I permit a copy of this authorization to be used in place of the original. Either my insurance company or I may revoke this authorization at any time in writing.

Date _____ Signature _____

(Patient, parent or guardian)

Advanced Foot Care

Craig P. Herman, D.P.M.

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (please print)

Date

Parent or Authorized Representative (if applicable)

Signature