Dan Preece, DPM
Darren Groberg, DPM

Salt Lake Podiatry Center
Foot & Ankle Specialists

PATIENT REGISTRATION

DEMOGRAPHICS:

PATIENT NAME: _____ _____ _____
FIRST MIDDLE LAST

STREET ADDRESS:_____

CITY:_____STATE:_____ZIP CODE:_____

DATE OF BIRTH: MONTH _____ DAY_____ YEAR_____

MALE_____ FEMALE_____

PREFERRED LANGUAGE _____ ETHNICITY/RACE _____

HOME PHONE:_____CELL:_____WORK:_____

EMAIL ADDRESS:_____

EMERGENCY CONTACT:_____ PHONE NUMBER:_____

RELATIONSHIP: _____

INSURANCE INFORMATION:

ARE YOU THE POLICY HOLDER? _____

IF NOT, NAME AND DATE OF BIRTH OF POLICY HOLDER. _____

PHYSICIAN INFORMATION:

PRIMARY CARE DOCTOR: _____ PHONE NUMBER: _____

DIABETIC DOCTOR: _____ PHONE NUMBER: _____

REFERRAL:

WHO MAY WE THANK FOR REFERRING YOU TO THIS OFFICE?_____

PAYMENT POLICY

CO-PAYMENT ON YOUR HEALTH INSURANCE IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. AS A COURTESY, WE WILL BILL BOTH YOUR PRIMARY AND SECONDARY INSURANCE PROVIDED ALL BILLING INFORMATION HAS BEEN SUBMITTED AT THE TIME OF YOUR VISIT. IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE COVERAGE REGARDING X-RAYS, EXAMS AND MAJOR SERVICES. IT IS IMPOSSIBLE FOR US TO KNOW THE COVERAGE OF ALL INSURANCE PLANS. WE WILL DO THE BEST WE CAN IN RETRIEVING YOUR BENEFITS. HOWEVER, PROVISIONS AND EXCLUSIONS SUCH AS NON- ALLOWED CHARGES, NON COVERED SERVICES, ORTHOTICS, NOT MEDICALLY NECESSARY SERVICES OR OTHER FACTORS MAY COME INTO PLAY. WE RESERVE THE RIGHT TO CHARGE INTEREST ON YOUR ACCOUNT AT THE RATE OF 1.5% PER MONTH ON ANY BALANCE OF 60 DAYS OR MORE. COLLECTION FEES AND RELATED EXPENSES (INCLUDING ATTORNEY FEES) WILL BE THE RESPONSIBILITY OF THE PATIENT. I AUTHORIZE PAYMENT OF THE MEDICAL BENEFITS TO THE PHYSICIAN HEREIN FOR MEDICAL SERVICES RENDERED. A PHOTOCOPY OF THIS SIGNATURE IS VALID AS AN ORIGINAL. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED FOR THE PROCESSING OF THE INSURANCE FORM.

SIGNATURE_____DATE_____