

**METRO FOOT & ANKLE**  
Daniel Saunders, DPM, FACFAS,

**NEW PATIENT REGISTRATION**

\_\_\_\_\_  
First Name Last Name MI Date of Birth

Gender M F SSN Driver's License State

Marital Status Ethnicity Race (Please circle)  
Married Hispanic/Latino American Indian/ Alaskan Native White  
Single Non-Hispanic Asian Other  
Divorced Decline Black or African American Decline  
Widowed Native Hawaiian/ Other Pacific Islander

Preferred Language English Spanish Other \_\_\_\_\_

\_\_\_\_\_  
Address Apt City State Zip

\_\_\_\_\_  
Home Phone Cell Phone Work Phone Emergency Contact

E-mail Address \_\_\_\_\_ Type of Employment \_\_\_\_\_

**INSURANCE INFORMATION (Please provide a copy)**

\_\_\_\_\_  
1) Insurance Name Policy Holder Relationship 2) Insurance Name Policy Holder Relationship

**GUARANTOR (Please fill out for patients under the age of 18)**

\_\_\_\_\_  
First Name Last Name MI Date of Birth

\_\_\_\_\_  
Address Apt City State Zip

\_\_\_\_\_  
SSN Phone Relationship to Patient

**PHARMACY/ FAMILY DOCTOR INFORMATION**

\_\_\_\_\_  
Family Physician Office Telephone

\_\_\_\_\_  
Pharmacy Name Street City Telephone

How did you arrive at Metro Foot & Ankle? Referred by \_\_\_\_\_

Google/Internet ZocDoc Insurance Dr. Referral \_\_\_\_\_ Friend/Family

**ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize payment of any medical insurance benefits to the above named physician/group. I hereby authorize Metro Foot and Ankle, PC to furnish my insurance carrier(s) any information that they may request in order to process a claim for medical services rendered by a physician of Metro Foot and Ankle, PC. I agree to pay all charges incurred for medical services and understand that I am financially responsible regardless of insurance coverage. I also agree that it is my sole responsibility to provide this office with any changes or updates to my insurance coverage or personal information. I am aware that a copy of HIPPA guideline is available for my review at anytime in the front office. I agree to provide 24hr notice for appointment cancellation to avoid a fee. There is a \$25 fee for failing to keep your appointment. I understand that if I fail to make payment for services rendered, my account may be turned over to a collection agency, and a 40% fee will be added to any balance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Self/Guarantor

Financial Policy: Payment is due in full at the time of service to avoid potential finance charges