PATIENT REGISTRATION ASSOCIATED FOOT SURGEONS

WILLIAM H. DABDOUB, DPM
TYLER P. MANCIL, DPM

First Name | Middle Initial | Last Name

Social Security # _____-_____-_____ | Date of Birth ____/____/____ | Gender ❑ Male ❑ Female | Marital Status ❑ Single ❑ Married ❑ Other | ❑ Student

Home Address | City | State | Zip

Home Phone (____) ____- _____ | Work Phone (____) ____- _____ | Cell Phone (____) ____- _____ | Email

Mailing Address | City | State | Zip

Race ❑ Not Specified
❑ American Indian ❑ Asian ❑ Alaska Native
❑ Black/African American ❑ Native Hawaiian ❑ White

Ethnicity ❑ Not Specified
❑ Hispanic
❑ Non Hispanic/Latino

Preferred Language

Employment
❑ Full-Time ❑ Part-Time ❑ Retired ❑ Unemployed

Employer Name

Drivers License # | State

Primary Insurance- copy of card required for claim

Insurance Name | Eligibility Phone (____) ____- _____

Medical Claims Address

ID # | Group #

Insured Name | Relationship to Insured ❑ Self ❑ Spouse ❑ Child

Insured Date of Birth _____/_____/_____ | Insured Social Security # _____-_____-_____

Insured Employer Name | Employer/HR Phone # (____) ____- _____

Secondary Insurance

Insurance Name | Eligibility Phone (____) ____- _____

Medical Claims Address

IS # | Group #

Insured Name | Relationship to Insured ❑ Self ❑ Spouse ❑ Child

Insured Date of Birth _____/_____/_____ | Insured Social Security # _____-_____-_____

Insured Employer Name | Employer/HR Phone # (____) ____- _____

Emergency Contact Name | Relationship ❑ Family ❑ Friend ❑ Spouse | Home Phone (____) ____- _____ | Call Phone (____) ____- _____

Primary Care Physician | Office Phone (____) ____- _____

Referred By
❑ Friend ❑ Insurance ❑ Internet ❑ Magazine
❑ Newspaper ❑ Phone Book ❑ Referring Dr.

Your Claim is ❑ Compensable/Work Related ❑ Automobile ❑ Other Liability ❑ Not Work/Auto/Liability

Privacy Information

Circle phone number and time of day where we can contact/leave you message(s)? Home: AM/PM Work: AM/PM Cell: AM/PM
Name person(s) who can have access to your records/PHI or pick up items for you:

Attest

I do hereby attest that this information is true, accurate, and complete to the best of my knowledge, I understand that any falsification, omission, or concealment of any material fact may subject me to all fees for services and/or other liability. I also understand that I am to notify Associated Foot Surgeons immediately of any changes to the above information and annually upon the office's request.

Print Name of Patient or Legal Authorized Representative | Signature | Relationship to Patient | Date

Associated Foot Surgeons
Drs. Dabdoub & Mancil
108 Smart Place
Slidell, LA 70458
(985) 649-0002
(985) 649-0034 Fax

AUTHORIZATION FOR RELEASE OF PHI INFORMATION

I hereby authorize Associated Foot Surgeons to disclose my protected health information (PHI) as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form if I ask for it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

I authorize Associated Foot Surgeons to disclose my protected health information (PHI) to the following persons/organizations:

Primary Care Physician or Other Physician:_____

DME Vendor for Diabetic Shoes or Equipment: ☐ I give permission to release documentation for DME order

Patient name:_____ **Date of birth:**_____

The specific information to be released/disclosed is specified below:

☐ **Complete Medical Record**

Or specify one or more of the following:

☐ Operative Reports	☐ X-rays
☐ Progress Notes	☐ Billing and Claim Records
☐ Laboratory	☐ (Other – specify) _____

This information is to be used/disclosed for the following purpose(s):_____

_____ _____

Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

Printed name of patient's representative (if applicable):_____

Relationship to the patient (if applicable):_____

*** YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT***