Chapel Hill Foot And Ankle Associates, P.A.

Patient Registration Form

Please Fill Out Completely

Last Name ______________________ First Name _____________________ MI ______

Address ____

City __________________________________ State _____________ Zip ____________

Phone No.s Home _______________________ Work _____________________________

Cell __________________________________ Other______________________________

Email Address ___________________________ Fax ____________________________

Birthdate ______________________ Age ______ Social Security # ________________

Marital Status (Circle) Married Single Widowed Separated Divorced

Are you a student? Yes ______ No ______ If yes: Full time ______ Part Time ______

Employer Name ___________________________________ Retired: Yes ____ No

Medical Doctor's Name ______________________________ City/Clinic _______________

How were you referred to our office?

Doctor ☐ Patient ☐ Yellow Pages ☐ Directory ☐ Ad ☐ Web Site ☐ Other _______

Name ____

Emergency Contact Name ____

Contact No. ________________________ Relationship to Patient __________________

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 choose, and understand the Notice. Initial _____

Date _______________________ Patient Signature _____________________________

Please have insurance cards available so we can make copies. It is your responsibility to notify the office staff if your insurance or any of your personal information changes.

ACKNOWLEDGEMENT 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 choose) and understand the Notice.

____ __________________________
Patient Name (please print) Date

____
Parent or Authorized Representative (if applicable)

____
Signature