BIRCH TREE PODIATRY GROUP, P.C.
FOOT AND ANKLE

PATIENT REGISTRATION

LAST NAME, FIRST, MIDDLE (Preferred)	DATE OF BIRTH / / AGE	SS#
MALE/FEMALE MARITAL STATUS S / M / W / D	PHONE (HOME)	
BILLING ADDRESS	CITY	STATE ZIP
EMPLOYER	PHONE (WORK) ext.	
SPOUSE'S NAME (If under 18, Parent/Guardian)	SPOUSE'S DATE OF BIRTH / /	SS#
EMERGENCY CONTACT (Other than spouse)	PHONE	RELATIONSHIP

REFERRING SOURCE: Friend Physician Other Name: ____________

Insured Cardholders information	Copy of back of Insurance Card
Full Name:	
Date of birth:	
Place of Employment:	
Social Security #:	

Authorization of Treatment and Assignment of Benefit

I authorize Randy G. Hartman/Daniel T. Lathrop to treat me. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Birch Tree Podiatry Group, P.C. for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

I understand that if my physician, or any person employed by or under the direction and control of my physician(s), is directly exposed to my body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my body fluids.

Patient Signature ______________________________ Date ____________