



Chad E. Webster, DPM
Julie Kate Webster, DPM
Christopher L. Hendrix, DPM

PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name: _____		First Name: _____	
Address: _____			
City: _____		State: _____	Zip: _____
Home Phone: (____) _____		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single	
Mobile Phone: (____) _____		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Social Security Number: _____		Date of Birth: ____/____/____ Age ____	
Emergency Contact: _____		Phone: (____) _____	

Referring Doctor: _____ Phone: (____) _____
Primary Care Physician: _____ Phone: (____) _____

INSURANCE INFORMATION:

Primary Insurance: _____	
How much is your Co-pay? \$ _____	Is a Referral Required? <input type="checkbox"/> Yes <input type="checkbox"/> No
Who is the Policy Holder? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other	
Policy Holder's Information (If Other Than Self)	
Name: _____	
Social Security Number: _____ Date of Birth: ____/____/____	
Address: _____	
City: _____ State: _____ Zip: _____	
Secondary Insurance: _____	
Who is the Policy Holder? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other	
Policy Holder's Information (If Other Than Self)	
Name: _____	
Social Security Number: _____ Date of Birth: ____/____/____	
Address: _____	
City: _____ State: _____ Zip: _____	

Employer Name: _____ Phone: (____) _____

How did you hear about Mid-South Foot & Ankle Specialists?
 Doctor Family Friend Insurance Website
 Yellow Pages Newspaper Ad Other _____

MEDICARE PATIENTS: Date Last Seen by Primary Care Physician: ____/____/____

Is today's visit due to an injury? Yes No
If Yes: Date of Injury: _____
Workers Compensation Claim Yes No
Motor Vehicle Accident Yes No
Litigation Pending Yes No



Chad E. Webster, DPM
Julie Kate Webster, DPM
Christopher L. Hendrix, DPM

Financial Policy for Mid-South Foot & Ankle Specialists

Assignment and Release

I hereby authorize payment to be made directly to Mid-South Foot & Ankle Specialists. I fully understand that I am responsible for all charges incurred by me or my dependents and if my account becomes delinquent and legal actions becomes necessary, I agree to pay all attorney and collection fees acquired. For purposes of processing my claims, continuing medical care or to forward to a collection service I authorize the release of my information.

Patient or Guardian

Date

Consent to Photography

I authorize Mid-South Foot & Ankle Specialists to obtain and use photography as needed.

Patient or Guardian

Date

HIPAA

I have read and understand the Privacy Policy Agreement.

Patient or Guardian

Date