McKenzie-Hastings Institute For Foot & Ankle Surgery Patient Registration

Patient Name:____Gender:________________

Birthdate:________________Social Security:_____________________ Email:___________________________

Address:____

Home Phone:______________________Cell:______________________Work:________________________

Pharmacy:________________________Location:___________________Phone:______________________

Responsible Party (if other than patient):____

Relationship:___________________ Birthdate:________________Social Security:______________________

Address:____

Home Phone:______________________Cell:______________________Work:________________________

Employer Name:___________________________________Occupation:____________________________

Address:____

Primary Insurance:____Effective Date:_____________________

Group #:______________________________________ID #:_______________________________________

Policy Holder's Name (if other than patient):____

Relationship:___________________ Birthdate:________________Social Security:______________________

Secondary Insurance:_______________________________________Effective Date:____________________

Group #:______________________________________ID #:_______________________________________

Policy Holder's Name (if other than patient):____

Relationship:___________________ Birthdate:________________Social Security:______________________

Tertiary Insurance:_______________________________________Effective Date:____________________

Group #:______________________________________ID #:_______________________________________

Policy Holder's Name (if other than patient):____

Relationship:___________________ Birthdate:________________Social Security:______________________

Emergency Contact:_________________________________Relationship:____________________________

Address:____

Home Phone:______________________Cell:______________________Work:________________________

When confirming your appointment, may we leave a message on your machine/voicemail? ____ YES____NO

Please arrive 15 minutes prior to your appointment. We ask for a minimum of 24-hour notice for the canceling of your appointment. **If you do not show for your scheduled appointment or cancel within the 24-hour notice, there will be a charge of $50.00**.

Please sign below you acknowledge that the above information you provided is both accurate, complete, and up-to-date.

Signature:____Date:______________________

McKenzie-Hastings Institute For Foot & Ankle Surgery HIPPA Policy Acknowledgement

I acknowledge that I have been given the opportunity to read, review, and/or received paper copies of the Notice of Privacy Practices concerning protected health information (PHI). I give permission to the person(s) listed below- such as a spouse, parent/child, legal guardian, healthcare proxy, medical director, or power of attorney- to receive protected PHI or other authorization. I understand this form is legally binding and that I may revoke at any time by submitting my request to change, add, or terminate such permission in writing.

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Signature:____Date:______________________

Please return forms to:

Email: mhifeet@yahoo.com

Fax: 757-638-1823

Mail: MHI, 1520 Breezeport Way, Suite 100, Suffolk, VA 23435

Or just bring them with you to your first appointment.