SIGNATURE
MEDICAL GROUP OF KC, P.A.

ASSOCIATED PODIATRISTS PATIENT REGISTRATION

Date: _____ Podiatrist: _____

Primary Care Physician: _____ Last Date Seen by PCP: _____

PATIENT INFORMATION

Please provide all patient contact information that may be used for communications from AP/SMG-KC:

Name (First, Middle, Last): _____ Email: _____

Address: _____

Primary Phone: _____ Secondary Phone: _____

Date of Birth: _____ Gender: ☐ M ☐ F Marital Status: _____

Race: _____ Primary Language: _____

Ethnicity: _____ SSN: _____

Employer/School: _____ Work Phone: _____

Work Address: _____

Occupation: _____ Who referred you to our practice? _____

Reason for today's visit: _____

IN CASE OF EMERGENCY / HIPAA RELEASE INFORMATION

Name (First, Middle, Last): _____ Relationship: _____

Phone: _____ `Alternate Phone: _____

HEALTH INSURANCE INFORMATION

Primary Insurance Name: _____

ID #: _____ Group #: _____

Policy Owner Name: _____ Policy Owner DOB and Relationship to Patient: _____

Secondary Insurance Name: _____

ID #: _____ Group #: _____

Policy Owner Name: _____ Policy Owner DOB and Relationship to Patient: _____

*AP/SMG-KC is not responsible for verification of in-network participation with your insurance carrier. ____ (Initial Here)

I hereby authorize AP to release medical information necessary for insurance reimbursement. I hereby authorize and assign payment directly to AP/SMG-KC for insurance benefits herein specified and otherwise payable to me. I understand that I am financially responsible to AP/SMG-KC for all charges incurred, regardless of potential insurance benefits. I authorize AP's healthcare providers to administer medical treatment as is necessary for a patient in my condition.

Signature: _____ Date: _____

Revised 7/2020