Bullitt County Foot & Ankle Center, P.S.C
421 Adam Shepherd Parkway, Suite #100
Shepherdsville, KY 40165
502-543-1553

Patient Registration Information

Last Name: ____________________ First Name: ____________________ MI: ____________
Address: ______________________________ City: ________________ State: ________ Zip: ______
Date of Birth: ________________ Age: ________ Social Security #: ______________________
(Information required by Insurance) Sex: M/F Marital Status: M S D W
Race: ________________ Ethnicity: Hispanic/Not-Hispanic Primary Language: ____________
Primary Phone: ____________ Secondary Phone: ______________ Email: ________________
Spouse Name: __________________________ Social Security #: ______________________
Parent/Guardian Name (If Minor): ____________________ Social Security #: ______________
Employer: ____________________________ Work Phone: ____________________________
Work Status: Full Time__________ Part Time__________ Student____________
Emergency Contact: ________________ Relationship: ____________Phone: ____________
Primary Contact Physician: ____________________ Diabetic Care Physician: ______________
Address: ____ Phone: ______________________
HOW WERE YOU REFERRED TO OUR PRACTICE? ______________________________________

Person To Receive Bills or Responsible Party (Please Complete If Different Than Above)
Last Name: ______________________ First Name: ______________________ MI: __________
Address: ______________________ City: ____________________ State: ______ Zip: _______
Primary Phone: _______________ Secondary Phone: ______________ Work Phone: _________
Social Security #: ______________ Date of Birth: ____________ Sex: M/F Marital Status: M S D W

Insurance Information:
Primary Insurance: ______________________ Secondary Insurance: ______________________
Policy Holder's Name: ____________________ Policy Holder's Name: ______________________
Policy Holder's Employer: _________________ Policy Holder's Employer: __________________
Relationship to Patient: ___________________ Relationship to Patient: ___________________
DOB: _______ Sex: M/F SS#:_______________ DOB:_______ Sex: M/F SS#:_________________
Policy #: _______________Group #: _________ Policy #: ________________ Group #: _________

I understand that it is my responsibility to see a provider who participates in my insurance plan and I accept full financial responsibility for any charges denied if Bullitt County Foot & Ankle Center is not a participating provider. I authorize Bullitt County Foot & Ankle Center to release any and all information acquired in the course of my treatment to my insurance company and to all medical providers participating in my health care. I authorize payment of medical benefits directly to Bullitt County Foot & Ankle Center and accept full responsibility for all charges not paid by my insurance company.

Signature: ________________________________ **Date:** ________________
Patient/Parent/Guardian