TEXAS FOOT & ANKLE INSTITUTE, P.A.
Saldino Prosthetics & Orthotics, P.L.L.C

Michael C. Saldino, DPM, CPO

PATIENT REGISTRATION

DEMOGRAPHIC INFORMATION

Last Name: _____ First Name: _____ MI: _____ Gender: M or F

Date of Birth: _____ Age: _____ Social Security #: _____

Race: _____ Ethnicity: _____

Physical Address: _____

City: _____ St: _____ Zip: _____

Mailing Address (if different from Physical): _____

City: _____ St: _____ Zip: _____

Marital Status: ____ - Never Married ____ - Married ____ - Divorced ____ - Widowed ____ - Other

CONTACT INFORMATION

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Do you wish to receive electronic appointment reminder notifications thru email or text messaging? YES or NO

If yes, Do you prefer _____ - EMAIL ONLY

_____ - TEXT MESSAGE ONLY

_____ - EMAIL & TEXT MESSAGE

EMPLOYMENT STATUS

____- Employed ____- Unemployed ____- Full Time Student ____- Part Time Student ____- Retired

Business Name: _____ Occupation: _____

EMERGENCY CONTACT

Name: _____ Phone #: _____ Relationship to Patient: _____

INSURANCE INFORMATION

Primary Insurance: _____

Subscriber ID#: _____ Group #: _____

Insured First Name: _____ Last Name: _____

Social Security #: _____ DOB: _____ Phone #: _____

Relationship to Patient: _____

ADDITIONAL INSURANCE

Is the patient covered by additional insurance? (circle) YES or NO

Insurance Company: _____

Subscriber ID#: _____ Group #: _____

GUARANTOR INFORMATION (Person Responsible)

Is the guarantor the same as the patient?

_____ - YES **IF YES, YOU MAY SKIP THE REMAINDER OF THE GUARANTOR SECTION.**

_____ - NO **If NO, please fill out the following guarantor information.**

Last Name: _____ First Name: _____ MI: _____ Gender: M or F

Date of Birth: _____ Social Security #: _____

Race: _____ Ethnicity: _____

Mailing Address: _____

City: _____ St: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____

PATIENT ASSOCIATIONS

Primary Care Physician (PCP): _____

Facility/Location: _____

Estimated Date Last Seen By PCP: _____

Preferred Pharmacy: _____ Location (Street/City/State): _____

Whom may we thank for referring you to our practice?

A patient: _____

A physician: _____

Other: _____

Found us online: YES / NO

I, _____, understand the staff of Texas Foot & Ankle Institute /Saldino Prosthetics & Orthotics is authorized by me to disclose my Protected Health Information to the people that I have listed below.

1. _____ - relationship to you _____

2. _____ - relationship to you _____

AUTHORIZATION & ACKNOWLEDGEMENT

1. I acknowledge that I have received the Notice of Health Information Privacy Rights. (yellow sheet) Initials – X _____

2. I hereby state that the information given on pages 1-3 is true and correct to the best of my knowledge. I authorize Texas Foot & Ankle Institute/ Saldino Prosthetics & Orthotics to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payers, as required for my treatment of care and/or my claims filed.

X_____ _____ _____

Signature of Patient / Parent / Guardian **Printed Name** **Date**

3. I authorize direct payment to be made to Texas Foot & Ankle Institute/Saldino Prosthetics & Orthotics for any and all medical or surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility cannot be verified, I am responsible for all charges incurred.

X_____ _____ _____

Signature of Patient / Parent / Guardian **Printed Name** **Date**