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: ☐ - Not Hispanic or Latino ☐ - Hispanic or Latino ☐ - Other

Physical Address: _____

City: _____ St: _____ Zip: _____

Mailing Address (if different from Physical): _____

City: _____ St: _____ Zip: _____

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

EMPLOYMENT STATUS

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

If Employed: Business Name: _____ Occupation: _____

CONTACT INFORMATION

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

Email: _____

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: ☐ - Self ☐ - Spouse ☐ - Child ☐ - Other

ADDITIONAL INSURANCE

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

Insurance Company: _____

Subscriber ID#: _____ Group #: _____

GUARANTOR INFORMATION (Person Responsible) (Required for all patients under 18 years of age.)

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: ☐ - Not Hispanic or Latino ☐ - Hispanic or Latino ☐ - Other

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. _____ - (Initial) **I acknowledge that I have received the Notice of Health Information Privacy Rights. (yellow sheet)**

2. _____ - (Initial) **I hereby state that the information given on pages 1-2 is true and correct to the best of my knowledge. I authorize Texas Foot & Ankle Institute/ Saldino Prosthetics & Orthotics to release and/or file 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.**

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 I am responsible for any copay, deductible and coinsurance amounts from my insurance. 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**