

Welcome to
Foot & Ankle Medicine & Surgery Clinic - Dr. Isaac Tabari

Board Certified, ABPOPPM

136 East 57th St, 6th Floor, NY, NY 10022 (212)288-3137 www.footdocnyc.com

PATIENT REGISTRATION

Patient Information

Patient Name: Last		First	M.I.	<input type="checkbox"/> M <input type="checkbox"/> F
By what name to you preferred to be addressed?			Single	Married
Widowed				
Other				
Patient's Address:				
City		State	Zip	
Home Phone:	Work Phone:	Cell Phone:	E-mail address:	
Social Security #:	Birthdate:		Age:	
Employer / School		Occupation:		
Emergency Contact:			Phone#:	
Would you like to receive occasional foot health information on E-mail? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Insurance

Name of insured (<u>if other than self</u>)		Insured's Birth Date:		
Name of insured's employer:		Insured's work phone number:		
Patient is: <input type="checkbox"/> Subscriber <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent				
We are required to have a copy of your insurance card(s) on file in order to bill your insurance for you.				
Insurance Company:		Member ID#:	Group #	

L&I Injury

Date of Injury:	Type of Injury:	<input type="checkbox"/> Work	<input type="checkbox"/> Auto	<input type="checkbox"/> Other
Has a claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Claim#:	Where was claim filed?	
Cause of injury:				

Referral

Referred By:				
<input type="checkbox"/> Friend (name): _____		<input type="checkbox"/> Doctor (name): _____		
<input type="checkbox"/> Family (name): _____		<input type="checkbox"/> Web search <input type="checkbox"/> Other: _____		
Primary Care Physician and Clinic Name			Phone #:	

Signature

Release of Benefits Information :
 I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctors office will bill my insurance as a courtesy and that I am responsible for all co-payments, deductibles and non-covered services. I authorize the release of information required to process my claims. (If not signed payment due at time of service)
ALL CO-PAYMENTS DUE ON DAY OF SERVICE.

Patient Signature: _____ Date: _____