WELCOME TO OUR OFFICE

Darin Alan Bocian, DPM, FACFAS

Podiatric Medicine and Surgery
Certified by The American Board of Foot and Ankle Surgery
Fellow American College of Foot and Ankle Surgeons

PATIENT REGISTRATION

NAME:_____
Last First Middle Initial

ADDRESS:_____
Street or P.O. Box Apartment# City State Zip

MAILING-ADDRESS:_____
Street or P.O. Box Apartment# City State Zip

PHONE: HOME #:_____ CELL #:_____ WORK #:_____

MARITAL STATUS: S M W D MALE: _____ FEMALE:_____ BIRTHDATE: _____/_____/_____

EMPLOYER: _____ PRIMARY PHYSICIAN:_____

EMAIL: _____ HOW WERE YOU REFERRED TO OUR OFFICE?:_____

PHARMACY: _____ LOCATION: _____

IN CASE OF EMERGENCY, CONTACT: _____ _____
Name Phone #

_____
Address City State Zip

INSURANCE INFORMATION

POLICYHOLDER NAME: _____ BIRTHDATE: _____/_____/_____

PRIMARY INSURANCE:_____ MEMBER ID #: _____

SECONDARY INSURANCE:_____MEMBER ID #: _____

PATIENT PRIVACY: Our practice is committed to securing the privacy of your health information. Accordingly, we have posted our practice's Notice of privacy in the reception area. You are not required to read this notice; however, we would like your acknowledgment that you have been notified that the practice has such a notice of privacy practices. By signing this form, I realize that I am giving Dr. Bocian permission to treat my condition in a manner that is reasonable and acceptable with today's medical standards. I understand I have the right to refuse treatment at any given time during the course of treatment. I hereby authorize release of information for insurance purposes. To the best of my knowledge, the above information is complete and accurate. I understand that Darin Alan Bocian, DPM will make all efforts in collecting adequate reimbursement from my medical insurance. Any unpaid services such as office visits, annual deductibles, co-payments, insurance rejections, cash charges, etc. are my complete responsibility, and I will make payment to Darin Alan Bocian, DPM in a timely manner.

SIGNED: _____ DATE: _____