Family Footcare, PC

Milton Stern, DPM - Randy Kaplan, DPM - Cindy Pavicic, DPM

Patient Registration

Date:

Name:

Address:

City:

State: Zipcode:

Date of Birth:

SSN:

Home Phone:

Cell Phone:

E-Mail: (Very important to us)

How did you hear about us?

Marital Status: Single

Gender: Male

Employer Name:

Work Phone:

Family Physician:

Phone:

Emergency Contact:

Phone:

Use this section if insurance is in patient's name.

Primary Insurance:

Insurance Numbers:

Secondary Insurance:

Insurance Numbers:

Use this section if insurance is in someone elses name.

Primary Insurance:

Insurance Numbers:

Secondary Insurance:

Insurance Numbers:

Insured relationship to patient: ☐ Spouse ☐ Child ☐ Parent Other:

Insurance Verification: **Office Use: Do not fill out**

Is insurance active? Y N Co-pay: _____ Encounter Fee: _____ Deductible: _____

Is referral needed? Y N Do we have one? Y N Orthotics covered? Y N

Any restrictions to foot care? _____

Verified by: TM CM Other: _____ Date: _____

29355 Northwestern Hwy. Suite 110 Southfield, MI 48034 (248) 945-1000 Fax: (248) 945-1001