Welcome to

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

Board Certified, ABPOPPM

136 East 57th St, 8th Floor, NY, NY 10022 (212)288-3137 www.footdocnyc.com

PATIENT REGISTRATION

Patient Information

Patient Name: Last First M.I. ☐ M ☐ 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 heatlh information on E-mail? ☐ Yes ☐ No

Insurance

Name of insured (if other than self) Insured's Birth Date:

Name of insured's employer: Insured's work phone number:

Patient is: ☐ Subscriber ☐ Spouse ☐ 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: ☐ Work ☐ Auto ☐ Other

Has a claim been filed? ☐ Yes ☐ No Claim#: Where was claim filed?

Cause of injury:

Referral

Referred By:

☐ Friend (name):____________________ ☐ Doctor (name):________________________

☐ Family (name): ____________________ ☐ Web search ☐ 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:______________________________

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