DAVID A. CHARNOTA, D.P.M.
APLINE FOOT SPECIALISTS, P.C.
REGISTRATION

Date____________ Home Phone____________________ Cell Phone____________________ E-Mail___________________

Patient____
Last Name First Name Initial
Street Address____

City ____ State__________________________ Zip__________________

Sex ☐ M ☐ F Age____ Birth Date___/___/______ ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Social Security #____ Driver's License #_____________________________________
Student ☐ Full-time ☐ Part-time Whom may we thank for referring you? ____
Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other____
Condition Related ☐ Illness ☐ Employment ☐ Auto ☐ Other____

PATIENT'S EMPLOYER	Company Name___________________________________ Occupation_____________________________ Address_______________________ Work Phone_____________________ ☐ Full-time ☐ Part-time City____ State__________ Zip_____________
PRIMARY INSURANCE INFORMATION	Name____ Birth Date_____/_____/__________ Last Name First Name Initial Policy/Group#______________________ ID#_______________ Social Security #___________________ Employer's Name____ Occupation_______________________ Address____ Phone___________________________ City____ State__________ Zip_____________
ADDITIONAL INSURANCE INFORMATION	Is Patient covered by other insurance? ☐ Yes ☐ No Name Insurance Co.________________ Name of Insured____ Ins. Birth Date_____________________ ID#____ Policy/Group#_____________________
PATIENT BILLING INFORMATION	Person responsible for account____________________________ Relationship_______________________ Street Address____ Home Phone______________________ City____ State__________ Zip_____________
MEDICAL AND LEGAL INFORMATION	Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ☐ Yes ☐ No Your Initials:_______________ Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician__________________________ Person to contact in emergency (Name and Phone #)____ Attorney____ Telephone______________________________ Address____
PATIENT AGREEMENT	LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS In considering the amount of medical expenses to be incurred, I the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to David A. Charnota, D.P.M., all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process the claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. ______________________________ ______________________ Signature of Insured/ Guardian Date