# David G. Robbins, DPM, FACFAS
# REGISTRATION FORM
(Please Print)

Today's date:

## PATIENT INFORMATION

| Patient's last name: | First: | Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
|---|---|---|---|---|---|

Birth date:    /    /    Age:        Sex: ❑ M   ❑ F        Home phone #:

Street address:        Social Security #:        (    )

Cell Phone #:

City:        State:        ZIP Code:        (    )

Occupation:        Employer:        Employer phone #:

Referral Needed:   ❑ Y   ❑ N    Race:        Hispanic ❑   Non Hispanic ❑ (please check one)        (    )

Primary Physician:        Primary Physician Phone:   (    )

Date of Last Physical:        Referred by:

## INSURANCE INFORMATION
(Please give your insurance card to the receptionist.)

Person responsible for bill:        Birth date:    /    /        Address (if different):        Home phone: (    )

Please indicate primary insurance:   ❑ Medicare   ❑ BC/BS   ❑ The Empire Plan   ❑ GHI   ❑ United Health

❑ Aetna   ❑ Oxford   ❑ Cigna   ❑ Healthcare Partners   ❑ HIP   ❑ Other

| Subscriber's name: | Subscriber's S.S. no.: | Birth date:    /    / | Group no.: | Policy no.: | Co-payment: $ |
|---|---|---|---|---|---|

Patient's relationship to subscriber:   ❑ Self   ❑ Spouse   ❑ Child   ❑ Other

| Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.: |
|---|---|---|---|

Patient's relationship to subscriber:   ❑ Self   ❑ Spouse   ❑ Child   ❑ Other

## IN CASE OF EMERGENCY

| Name of local friend or relative (not living at same address): | Relationship to patient: | Phone #: (    ) |
|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. David Robbins or insurance company to release any information required to process my claims.

_Patient/Guardian signature_        _Date_