AZ Podiatry & Foot Surgery

Office of Todd Lamster, DPM
Diplomate, American Board of Podiatric Surgery
Diplomate, American Board of Podiatric Medicine

PATIENT REGISTRATION FORM Date _____

Name _____ DOB _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Email _____

SSN _____ Gender (choose one): male female other

Marital Status (choose one): married divorced single widowed

Emergency Contact _____ Cell Number _____

Employment (Job Description) _____

Employer _____ Work Phone _____

Primary Insurance _____ Phone Number _____

ID Number _____ Group Number _____

Name of Insured Person _____ DOB _____

Relationship to Patient _____ SSN _____

Secondary Insurance _____ Phone Number _____

ID Number _____ Group Number _____

Name of Insured Person _____ DOB _____

Relationship to Patient _____ SSN _____

By completing and signing this document, I acknowledge that all information is accurate and true. I acknowledge that all insurance information supplied is up-to-date, accurate and true. I understand that I will be asked for current insurance cards to verify this information. Furthermore, I understand that this information will be used to submit claims for payment. If any information is inaccurate or untrue, I understand that it will be my sole responsibility to pay for all services rendered.

I hereby assign my insurance benefits to be paid to Arizona Podiatry and Foot Surgery. I understand that I am financially responsible for this bill regardless of insurance coverage. I also authorize the release of any information required in the processing of insurance claims. I understand that I am responsible for charges not covered or reimbursed by the above listed insurance companies. I agree, in the event of nonpayment, to assume the costs of services rendered.

SIGNATURE _____ *DATE* _____

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