

WESTCHESTER FOOT CARE — REGISTRATION HISTORY

Patient Information

Last Name	First Name:	M.I.
Date of Birth: / /	Age:	Social Security# - -
Sex: F M	Married:	Single: Divorced: Widowed:
Street Address:	Apt#:	City: State: Zip:
Home Phone#	Cell#	
Work Phone#	E-Mail:	
Drivers License:		
Emergency#	Relationship:	
Medical Doctor:	Phone#	

Primary Insurance Information

Name of Insurance:	Insurance ID#
Name of Employer:	Phone#
Employer Address:	
Policy Holder:	Relationship to Patient:

Guarantor Information

Check here if Same as Patient Information:	Sex: F M	
Last Name:	First Name:	M.I.
Date of Birth: / /	Social Security#	- -
Home Address:	Apt#	
City:	State:	Zip:
Home Phone#	Cell#	
Work Phone#	E-Mail:	
Drivers License:		
Relationship:		

Secondary Insurance Information

Check here if NO Secondary Insurance:	
Name of Insurance:	ID#
Name of Employer:	
Employer Address:	
Policy Holder:	Relationship to Patient:

Patient Signature: _____ **Date:** _____

Guarantor's Signature: _____ **Date:** _____