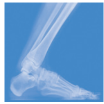
For Office Use Only



DR. DAVID C. STEGE

DIPLOMATE AMERICAN BOARD OF PODIATRIC SURGERY

Patient Registration

Last Name ___________________________ First Name _______________________ Middle I ____ Date of Birth _____________________

Home Address ____ Home Phone (_____) ________________

City _____________________________________ State _______ Zip ____________________ Cell Phone (_____) ________________

Social Security Number ________________________________ Age ___________ Marital Status: S M W D

Occupation __________________________________Employer Name ____

Employer's Address _______________________________________ Work Phone (_______) ____

Employer City____________________________ State _______Zip ________________

Name of Spouse/
Parent if Minor ____ Social Security Number __________________________________

Spouse/ Parent Employer ____ Work Phone (_____) __________________________

Employer's Address ____ City ______________________________ Zip ______________

Person Responsible for this account: ____

How were you referred to Dr. Stege? ____

Who is you Primary Care Physician? ______________________________ Address/City ____________________________________

Have you had prior foot or ankle surgery? ❏ Yes ❏ No Physician Name: ________________________ City _____________________

Reason for which you are seeking medical attention: ____

When did this problem begin? _____________________________ If accident or injury, Date of injury _____________________________

Are you allergic to any medication or substance? ❏ Yes ❏ No

Allergies: ____

____

Are you being treated for any medical conditions? ❏ Yes ❏ No

Please explain if Yes: ____

____

AUTHORIZATION TO RELEASE AND/OR OBTAIN INFORMATION AND RECORDS /AUTHORIZATION TO PAY:

I hereby authorize this physician/clinic to release and/or obtain any information required in the course of my examination or treatment. This includes sending records by fax machine. I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan.

I hereby authorize payment directly to the business office of this physician/clinic for the surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered or paid by my insurance in a timely manner.

SIGNED:____ **DATE:** ____________________