UNIVERSITY FOOT & ANKLE INSTITUTE
PATIENT REGISTRATION FORM

PHYSICIAN:

- ☐ DR. GARY BRISKIN
- ☐ DR. BOB BARAVARIAN
- ☐ DR. JASON MORRIS
- ☐ DR. AVANTI REDKAR
- ☐ DR. JUSTIN FRANSON
- ☐ DR. SYDNEY YAU
- ☐ DR. BRAYTON CAMPBELL
- ☐ DR. TANLER VOLKMANN

LOCATION:

- ☐ SANTA MONICA
- ☐ BEVERLY HILLS
- ☐ SHERMAN OAKS
- ☐ WEST HILLS
- ☐ SIMI VALLEY
- ☐ MANHATTAN BEACH
- ☐ VALENCIA
- ☐ SANTA BARBARA

PATIENT INFORMATION

LAST NAME	FIRST NAME		M.I.
ADDRESS	**CITY**	**STATE**	**ZIP CODE**
HOME PHONE	**WORK PHONE**	**CELL PHONE**	
SOCIAL SECURITY #	**SEX** M F	**DATE OF BIRTH**	**AGE**
EMAIL ADDRESS	**PLEASE CIRCLE THE BEST WAY TO CONTACT YOU** EMAIL HOME WORK CELL		

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

EMPLOYER	OCCUPATION
PRIMARY CARE PHYSICIAN	**PHONE**
REFERRED BY	**PHONE**

INSURANCE INFORMATION

INSURANCE TYPE (CIRCLE) MEDICARE PPO POS EPO HMO WC SELF PAY OTHER

PRIMARY INSURANCE	ID#	RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER
SECONDARY INSURANCE	**ID#**	**RELATIONSHIP TO INSURED** SELF SPOUSE CHILD OTHER

INSURED INFORMATION (IF OTHER THAN PATIENT)

INSURED LAST NAME	FIRST NAME	M.I.
SOCIAL SECURITY #	**DATE OF BIRTH**	**RELATIONSHIP TO INSURED** SELF SPOUSE CHILD OTHER

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize **University Foot & Ankle Institute** to use and disclose my individually identifiable Protected Health Information ("PHI") in the manner described below. I understand that my PHI may be re-disclosed by the person or entity receiving it and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such re-disclosure by the person or entity receiving my PHI. I voluntarily agree to this authorization, and I understand that my health care will not be affected if I do not sign this form.

☐ By checking this box, I hereby authorize the use of my PHI for the purpose of diagnosing, treating, consulting and referral.

☐ By checking this box, I hereby authorize the disclosure of my PHI to insurance carriers and/or its representatives for processing claims.

ASSIGNMENT OF BENEFITS

I hereby authorize payments to be made directly to University Foot & Ankle Institute for surgical and/or medical benefits, if any, otherwise payable to me for professional services rendered. I understand that I am financially responsible for the charges not covered by this Authorization. I further agree, in the event of Non-Payment, to bear the cost of reasonable legal fees should this be required. A photocopy of this Assignment shall be considered as effective and valid as the original.

SIGNATURE X _____ DATE _____

IF MINOR, PARENT/GUARDIAN MUST SIGN

_____ DATE _____

PLEASE PRINT PARENT/GUARDIAN NAME