Family Footcare, PC Patient Registration

You can fill out this interactive form and either bring it to the office at the time of your visit or fax it ahead of time to (248) 851-4901.

Personal Information:

Date: | Email:

Name:

Address:

City: | State: | Zip

Home Phone: | Date of Birth:

Cell Phone: | SSN:

Who may we thank for referring you to our office?

Marital Status:

◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Other

Name, Address and Phone Number of Family Physician:

Employment Information:

Employer Name:

Address:

City: | State: | Zip Code:

Phone: | EMail at Work:

Primary Insurance Information:

Insurance Name: | Insured Name:

Insurance Address: | Group Number: | Contract Number:

Insurance Phone Number:

Secondary Insurance Information:

Insurance Name: | Insured Name:

Insurance Address: | Group Number: | Contract Number:

Insurance Phone Number:

For Office Use Only: ◯ Insurance Verified By: _____ Date: _____

◯Needs Referral ◯$ Limit _____ ◯Deductible $ _____ ◯ OV Copay _____ ◯ Orthotics

Print Form