

**Garden State Foot & Ankle Center, LLC**  
**Scott R. Shrem, DPM AACFAS**

**PATIENT REGISTRATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Sex: \_\_\_ M \_\_\_ F Age: \_\_\_\_\_ Martial Status: \_\_\_\_\_ Race: \_\_\_\_\_ SS #: \_\_\_\_\_ -- \_\_\_\_\_ -- \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ Stat: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Pharmacy Name & Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Reason for Visit: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Last Seen by Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Insurance Information**

Responsible Party: \_\_\_\_\_ Address: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

\*Primary Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Patient Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ How long: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Co-pay Amount: \_\_\_\_\_ How did you learn about our office? : \_\_\_\_\_

**ASSIGNMENT, RELEASE & CONSENT**

I, the undersigned, have insurance coverage with \_\_\_\_\_ and assign directly to Dr. Scott R. Shrem all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not paid by insurance. **We Reserve the Right to Charge \$40.00 for Appointments Cancelled or Broken Without 24 Hours Advanced Notice.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions. I hereby give permission to Dr. Shrem to administer and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition. Due to the new **“Red Flag”** law instituted by the Federal Trade Commission, all patients are **required to present a driver’s license or other form of government issued picture identification.** This identification will be scanned into your account for future reference. This is required to prevent identity theft and to protect your insurance benefits. **I authorize Dr. Shrem to obtain my prescription history from my pharmacy. My signature below is also an acknowledgment that I have received a copy of “Notice of our Privacy Practices” Garden State Foot & Ankle Center, LLC.**

Signature of Insured/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits to be made either to me or on my behalf to Dr. Scott Shrem for any services furnished me by that physician. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible area based upon the charge determination of the Medicare carrier.

Signature of Beneficiary: \_\_\_\_\_ Date: \_\_\_\_\_