Northeast Wisconsin
Foot & Ankle Associates

PATIENT REGISTRATION

Today's Date: ___________________ **Patient of:** ☐ Dr. Tougas ☐ Dr. Schinke

Patient Name: ____ **Gender**: ☐ M ☐ F
First MI Last

Social Security Number: _______-_____-_______ **Date of Birth**: ___-___-___ **Age:** _______
(required by insurance co. to process claim)

Mailing Address: _______________________________ City/State:_______________________ Zip: ________

Phone (Home): ____________________ (Cell):_______________________ (Work) ______________________
OK to leave messages with: ☐ Anyone who answers phone ☐ Patient or spouse/partner ☐ Patient only

Is it OK to contact via email? ☐ **Yes**, email address_______________________________________ ☐ **No**

Emergency Contact:___________________________ Relationship: ______________Phone: _______________

If patient is a minor (list all that apply) :
Parent or Legal Guardian: ____Relationship: ______________
Address: _____________________________________ Phone:___________________ DOB: _____________
Parent or Legal Guardian: ____Relationship: ______________
Address: _____________________________________ Phone:___________________ DOB: _____________

Patient's Primary Care Physician: ____

Marital Status: ☐ Single ☐ Married, Name of Spouse: ____
Student Status: ☐ Full time Student ☐ Not a Student
Employment Status: ☐ Employed Full time ☐ Employed Part time ☐ Not Employed

Employer: ________________________________Occupation:____________________

How did you hear about our office?
☐ Dr. Referral (Name of Doctor: ________________________) ☐ Patient Referral ☐ Health Expo ☐ Seminar
☐ Website ☐ Internet ☐ Phonebook ☐ Shop with a Doc ☐ Other:__________________________

Primary Insurance Coverage:___________________________________ Effective Date: _____________
Policy Holder's Name (if not the patient): _____________________________________
Relationship to Patient: ___________
Policy Holder's DOB:_______________
Policy Holder's SSN:_______________________________(required for insurance processing)

Secondary Insurance Coverage:_________________________________ Effective Date: _____________
Policy Holder's Name (if not the patient): _____________________________________
Relationship to Patient: ___________
Policy Holder's DOB:_______________
Policy Holder's SSN:_______________________________(required for insurance processing)

Is This a Worker's Comp. Case? ☐ **No** ☐ **Yes** If Yes, Date of Injury:_________________________
Workers Comp. Carrier:____