Northeast Wisconsin
Foot & Ankle Associates

PATIENT REGISTRATION

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

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

Social Security Number: _______-_____-_______ **Date of Birth**: ___-___-___ **Age:** _______

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

Phone ( ) ____________________ ☐ Cell ☐ Landline ☐ Work

For appointment reminders, order notifications, and requests for you to call back …
Is it OK to leave messages: ☐ with anyone who answers ☐ with spouse/partner ☐ on voicemail
Is it OK to TEXT you? ☐ YES ☐ NO
Is it OK to EMAIL you? ☐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: _______________________________________
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 ☐ Internet
☐ Insurance Co ☐ Other:____

Primary Insurance Coverage:___________________________________ Effective Date: _____________
IF COVERAGE IS NOT THROUGH THE PATIENT:
Name of Member: ____________________________________ Relationship to Patient: ________________
Policy Holder's DOB:______________ Policy Holder's SSN:_____________________________ (required)

Secondary Insurance Coverage:_________________________________ Effective Date: _____________
IF COVERAGE IS NOT THROUGH THE PATIENT:
Name of Member: ____________________________________ Relationship to Patient: ________________
Policy Holder's DOB:______________ Policy Holder's SSN:_____________________________ (required)

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

Patient (or Parent/Guardian) Signature _____________________________________ **Date** __________