Dr. Timothy L Gardner DPM PC
Family Foot and Ankle Clinic

Patient Registration Form

TODAY'S DATE _____

PATIENT INFORMATION

LAST NAME	FIRST NAME	DATE OF BIRTH

SOCIAL SECURITY # (OR LAST 4 DIGITS)		MALE FEMALE
CONTACT PHONE NUMBER(S)		
EMAIL ADDRESS		

MAILING ADDRESS	CITY, STATE	ZIP

INSURANCE INFORMATION

SUBSCRIBER LAST NAME	FIRST NAME	DATE OF BIRTH

SUBSCRIBER RELATIONSHIP

SUBSCRIBER ID#	INSURANCE GROUP #	COPAY

INSURANCE PROVIDER PHONE NUMBER *ON BACK OF CARD*

SECONDARY INSURANCE

SUBSCRIBER ID#	INSURANCE GROUP #	COPAY

RESPONSIBLE PARTY

SELF OR OTHER

LAST NAME	FIRST NAME	DATE OF BIRTH

CONTACT PHONE NUMBER	EMAIL ADDRESS

PRIMARY CARE DOCTOR	PRACTICE NAME	PHONE NUMBER

PHARMACY	NAME/LOCATION	PHONE NUMBER

EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP	PHONE NUMBER