MICHAEL J. KELLEY, D.P.M.

PATIENT REGISTRATION FORM

(616) 874-8772 or (989) 291-5546
(800) 554-5124

PATIENT INFORMATION

Patient's Name: _____ **Occupation:** _____

Birthdate: _____**Email:** _____ **SS#**: _____

Gender: ____ M ____ F **Marital Status:** ____ M ____ S ____ D ____ W **Ethnicity:** ____ Hispanic/Latino ____ Other

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Language: _____ **Race**: ___African American ___American Indian ___ Asian ___Pacific Islander ___ White

Cell Phone: _____ **Home Phone**: _____ **Work Phone**: _____

Which phone do you prefer to receive calls? _____ **Can we leave a message?** ____ Yes ____ No

Would you like to receive alerts for upcoming appointments? _____ Yes ____ No If yes, ____ Email _____ Text

Primary Care Doctor: _____ **Location:** ___ _____

Pharmacy: _____ **Location**: _____

How did you hear about our office? _____

MEDICAL INSURANCE INFORMATION

Primary Insurance: _____ **COPY OF CARD REQUIRED**

Policy Holder's Name: _____ **Date of Birth:** _____

SS#: _____ **Relationship to Patient:** _____

Employer: _____

Secondary Insurance: _____ **COPY OF CARD REQUIRED**

Policy Holder's Name: _____ **Date of Birth:** _____

SS#: _____ **Relationship to Patient:** _____

Employer: _____

Responsible Party for Payment (if other than patient)

Name: _____ **Birthdate:** _____ **SS#:** _____

Address: _____ **Phone #**: _____**Relationship to Patient:** _____

EMERGENCY CONTACT

Name: _____ **Relationship to Patient:** _____

Address: _____ **Phone #:** _____

Payment is expected at the time services are rendered.

The policy of this office is to require payment at the time services are rendered. By signing below, I am stating that I understand this policy. I hereby authorize this office to furnish my designated insurance carrier or Social Security Administration, Health Care Financing Administration or intermediaries any necessary information concerning my present illness or injury. I authorize benefits under all claims to be made payable directly to this office. I understand I am financially responsible to the physician for any charges not covered by the insurer. In addition, I authorize release of necessary medical records to physicians to whom I am referred by this office.

Patient Signature (or Parent/Guardian if a minor): _____ **Date:** _____