Dr. Sherry Lu
Podiatrist
13425 Hoover Creek Blvd, #201
Charlotte, NC 28273

PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Last Name First Middle			☐ Mr. ☐ Mrs. ☐ Dr. ☐Miss ☐ Ms.	Marital Status (Circle One) Single/ Mar / Div / Sep / Wid
Nickname (Name I prefer to be called)	Birthdate (mm/dd/yyyy)	Sex ☐ M ☐ F	Spouse's Name	
Street Address	Social Security #	Home Phone # ( )		
City State Zip Code	E-Mail	Mobile Phone # ( )		
Employer	Employer Address	Employer/Work Phone # ( )		
Pharmacy Name & Phone #	Primary Care Physician (PCP)	Date PCP Last Seen		

PERSON RESPONSIBLE FOR BILL (IF DIFFERENT THAN ABOVE)

Name of Person Responsible for Bill	Birth Date (mm/dd/yyyy)	Sex ☐ M ☐ F	Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other
Street Address	Social Security #	Home Phone # ( )	
City State Zip Code	E-Mail	Mobile Phone # ( )	
Employer	Employer Address	Employer/Work Phone # ( )	

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD AND PHOTO ID TO RECEPTIONIST)

Primary Insurance	Subscriber Name		Birth Date (mm/dd/yyyy)		Social Security #
Insurance ID #	Group #	Policy #	Effective Date	Expiration Date	Co-Payment $
Secondary Insurance	Subscriber Name		Birth Date (mm/dd/yyyy)		Social Security #
Insurance ID #	Group #	Policy #	Effective Date	Expiration Date	Co-Payment $

IN CASE OF EMERGENCY

Name of Nearest Friend or Relative	Relationship to Patient	Home Phone # ( )	Work or Mobile Phone # ( )

REFERRAL

How did you learn about us? (Please check all that apply) ☐ Dr. _____ ☐ Hospital/ER ☐ Lecture ☐ Insurance Plan

☐ Phonebook ☐ Internet ☐ Website ☐ Friend/Family: _____ ☐ Other: _____

The above information is true to the best of my knowledge. I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Charlotte Foot Care Associates all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature below on all insurance submissions. Charlotte Foot Care Associates may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X _____

PATIENT/GAURDIAN SIGNATURE DATE

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