Jack Sherry, D.P.M.

1505 Mall Drive
Iowa City, Iowa 52240
319-337-2135

Patient Registration Form
(Please Print)

PATIENT INFORMATION

Patient's First Name:	MI:	Last Name:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Sex: ❑ M ❑ F

Preferred Name?	Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):

Social Security #:	Birth date: / /	E-Mail:

Street address:

City:	State:	Zip Code:	Home Phone #: ( )	Work Phone #: ( )	Cell Phone #: ( )

Primary Physician:	Referral Source: ❑ Newspaper ❑ Yellow Pages ❑ Patient: ❑ Other:

Primary Language: ❑ English ❑ Other (Please describe):	Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White	Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Marital status: ❑ Divorced ❑ Married ❑ Partner ❑ Single ❑ Widowed ❑ Legally Separated	Spouse's Name:	Student Status: ❑ Full Time ❑ Part Time ❑ Not a Student	Employment Status: ❑ Full Time ❑ Part Time ❑ Not Employed

Occupation:	Employer:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. #:	Birth date: / /	Group #:	Policy #:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other (Please Describe):

Please indicate secondary insurance:

Subscriber's name:	Subscriber's S.S. #:	Birth date: / /	Group #:	Policy #:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other (Please Describe):

Person responsible for bill:	Birth date: / /	Address (if different):	Contact # (if different): ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer Address:	Employer Phone #: ( )

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Phone Number to be reached: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Jack Sherry, D.P.M. or insurance company to release any information required to process my claims.

______________________________ ________________

Patient/Guardian signature *Date*