2 Pomperaug Office Park
Suite 106
Southbury, CT 06488

BARBARA KILKENNY DPM
JOSEPH ROGERS DPM

Office: 203-264-0800
Fax: 203-264-2657

PATIENT REGISTRATION

Patient Name: _____ Today's Date: _____

Address: _____ City: _____

State: _____ Zip _____ Email: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security# _____

Marital Status _____ Single _____ Married _____ Divorced _____ Widow Sex M/F _____

Primary Care Physician _____ City: _____ Date Last Seen: _____

Preferred Pharmacy _____ Phone _____

How did you hear about our office? _____ Paper _____ Internet _____ Friend _____ Physician _____ Other

Parent or Emergency Contact Information

Name _____ Relationship _____

Address _____ City _____

State _____ Zip _____ Phone _____

Patient Employer Information

Employer _____ Work Phone _____

Occupation _____

Insurance Information

Primary Insurance: _____ **Secondary Insurance**: _____

Insured's Name: _____ Insured's Name: _____

Date Of Birth: _____ Date Of Birth: _____

Relation to Insured: _____ Relation to Insured: _____

ID#: _____ ID# _____

Group #: _____ Group #: _____

I authorize payment of insurance benefit due me to be made directly to Dr Kilkenny. I understand that I am and remain fully responsible for these charges. I authorize release of any information concerning my (or my minor child's) healthcare and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I allow a copy of my signature to be for any outside medical record release. I acknowledge receipt of Notice of Privacy Practices for Protected Health Information. **Regardless of Insurance status, charges for services rendered at this office are ultimately the patient's responsibility. If your insurance requires a referral prior to treatment in our office it is YOUR responsibility to provide us with that referral.**

Patients Signature _____ Date: _____
(Parent or Guardian of Minor)

DO NOT MAIL BACK