J. Kevin Hardison, D.P.M.
Chaitalee Kardani, D.P.M.
335 Billingsley Rd. Suite 102
Charlotte, NC 28211
704-632-8032
Fax: 704-632-8034
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Patient Registration:

First Name: _____ Middle Name: _____
Last Name: _____
Street Address: _____ City, State, Zip: _____
Mailing Address: _____City, State, Zip: _____
Home Phone #: _____Work Phone #: _____
Mobile Phone #: _____ Date of Birth: _____
Social Security #: _____ Marital Status: _____
Emergency Contact Name: _____ Relationship: _____
Phone #: _____ Address: _____
How did you hear about us? _____

Responsible Party/ Name of Primary Cardholder:

Name: _____ Phone #: _____
Relationship to Patient: _____ Address: _____
Date of Birth: _____ Social Security #: _____

Employer Information:

Employer's Name: _____ Phone #: _____
Address: _____City, State, Zip: _____
May we leave messages at your work? YES NO

Medical Providers:

Primary Care Doctor: _____ Phone #: _____
Address: _____ City, State, Zip: _____
Date of Last Visit (approximate): _____

Pharmacy:

Pharmacy Name: _____ Phone #: _____
Address: _____ City, State, Zip: _____

I hereby guarantee payment of all charges incurred at Arch Podiatry. I hereby assign and direct to pay any and all benefits for medical services received directly to Arch Podiatry. I hereby authorize the release of any medical information requested by the insurance companies with the above assignment.

_____ _____
Signature-Responsible Party **Date**