

REGISTRATION

(PLEASE PRINT)

Date _____ Home Phone (_____) _____ Cell (_____) _____

Patient _____
Last Name First Name Middle Initial

Responsible Party (if a minor) _____

Street Address _____ E-mail _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____ Married Widowed Single Minor Separated Divorced Partnered for _____ years

Employer/School _____

Business/School Address _____

Occupation _____ Business/School Phone (_____) _____

Spouse (or responsible party) Name _____ Birthdate _____

Business Name and Address _____

Occupation _____ Business Phone (_____) _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse's Social Security # _____

Do you have Medical Insurance? No Yes ► If yes,

Name of Primary Insurer _____ Policyholder _____

Contract # _____ Group # _____ Subscriber # _____

Name of Secondary Insurer (if any) _____ Policyholder _____

Contract # _____ Group # _____ Subscriber # _____

Medicare Medicaid Claim ID # _____

If Welfare, your number _____ County of _____

In case of emergency, who should be notified? _____ Phone (_____) _____

How did you learn of our practice? _____

AUTHORIZATIONS

Insurance Assignment and Release

I certify that I have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named 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. This consent will end when my current treatment plan is completed or one year from the date signed below.

Medicare/Medigap Authorization

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to _____
Name of Doctor or Clinic
_____ for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian or Personal Representative

Date

Please print name of Beneficiary, Guardian or Personal Representative

Relationship to Beneficiary