

PATIENT REGISTRATION FORM

NAME _____ MARITAL STATUS _____ DATE OF BIRTH _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____ OCCUPATION _____

EMPLOYER NAME/ADDRESS _____

EMPLOYER'S PHONE _____

DRIVER LICENSE # _____ SS# _____

PARENT/GUARDIAN FOR THOSE UNDER 18 _____

SPOUSE/SIGNIFICANT OTHER NAME _____

EMERGENCY CONTACT NAME/ADDRESS _____

RELATIONSHIP TO PATIENT _____ PHONE _____

WHO IS YOUR PRIMARY CARE PHYSICIAN?

NAME _____

ADDRESS _____ PHONE _____ FAX _____

PLEASE LET US KNOW IF YOU WERE REFERRED TO US SO THAT WE MAY THANK THEM:

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of medical benefits to Richard L. Van Buskirk, D.O. for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

MEDICARE

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Richard L. Van Buskirk, D.O. to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

PATIENT NAME (PLEASE PRINT) _____ DATE _____

PARENT/GUARDIAN _____ SIGNATURE _____