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**

What are the problems for which you wish to be seen?

PAYMENT

I understand that I am financially responsible for all medical services provided to me by Richard L. Van Buskirk, D.O. and his medical office.

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 of in processing applications for financial benefits.

PATIENT NAME (PLEASE PRINT) **DATE**

PARENT/GUARDIAN **SIGNATURE**