PATIENT REGISTRATION FORM

NAME **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 PATIEN T
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.

I understand that Richard L. Van Buskirk, DO is not contracted with most medical insurers, including Medicare and Medicare Advantage. This means that neither Dr. Van Buskirk nor his patients can bill Medicare for the medical and osteopathic services provided.

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.

PATIENT NAME (PLEASE PRINT) **DATE**

PARENT/GUARDIAN **SIGNATURE**