

UPDATED: _____
UPDATED: _____
UPDATED: _____
UPDATED: _____

PATIENT REGISTRATION

TODAY'S DATE: _____ REFERRED BY: _____
IF YOU WERE NOT REFERRED HOW DID YOU HEAR ABOUT THE OFFICE? _____

PATIENT LAST NAME FIRST NAME MIDDLE INITIAL

SOCIAL SECURITY NUMBER DATE OF BIRTH AGE

ADDRESS STREET CITY, STATE, ZIP CODE

HOME PHONE NUMBER WORK NUMBER CELL PHONE
IS IT OKAY TO CALL YOU AT WORK? YES/ NO EXT. NUMBER _____

EMPLOYER EMPLOYER'S ADDRESS

SPOUSE'S NAME EMPLOYER EMPLOYER'S ADDRESS

RESPONSIBLE PARTY

(IF PATIENT IS NOT RESPONSIBLE FOR THE BILL, PLEASE INDICATE WHO IS)

NAME DATE OF BIRTH ADDRESS CITY, STATE ZIP CODE

HOME PHONE NUMBER RELATIONSHIP TO PATIENT EMPLOYER

INSURANCE INFORMATION

PLEASE PRESENT YOUR INSURANCE CARD TO THE FRONT DESK TO BE PHOTOCOPIED.

PRIMARY INSURANCE CO: _____ SECONDARY INSURANCE CO: _____

ASSIGNMENT OF BENEFITS, RELEASE OF INFORMATION AND PATIENT RESPONSIBILITY OF PAYMENT:

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BRIAN J. GRETEMAN, DPM, PA FOR PROFESSIONAL SERVICES RENDERED. ADDITIONALLY, I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THE CLAIM. I AM COMPLETELY AND FULLY RESPONSIBLE FOR INSURANCE DENIALS FOR NON-COVERED SERVICES, NON-COVERED SUPPLIES, CO-PAYS, AND CO-INSURANCES.

SIGNED _____ DATE _____