PATIENT REGISTRATION FORM: PLEASE PRINT

LAST NAME:_____FIRST_____MIDDLE_____

AGE:_____DATE OF BIRTH:_____SOCIAL SECURITY #_____MARITAL STATUS_____

ADDRESS:_____PHONE:_____

CITY_____STATE_____ZIP_____ADDITIONAL PHONE_____

EMPLOYER_____EMPLOYER PHONE_____

EMPLOYER ADDRESS_____

OCCUPATION_____

PERSON TO CONTACT IN CASE OF EMERGENCY:_____

ADDRESS_____PHONE_____

FINANCIAL RESPONSIBILITY:

LAST NAME_____FIRST_____MIDDLE____RELATIONSHIP TO PATIENT_____

ADDRESS:_____CITY/STATE/ZIP_____

PHONE:_____SECONDARY PHONE_____

SIGNATURE:_____DATE:_____

PRIMARY INSURANCE: Please present your insurance card and a photo ID to the receptionist

Name of Insurance company:_____CLAIMS ADDRESS:_____

POLICY #_____GROUP #_____

EFFECTIVE DATE:_____ **YOUR INSURANCE CARD MUST BE ACTIVE DURING THE TIME OF VISIT**

SUBSCRIBERS NAME:_____DOB_____SSN#_____

SECONDARY INSURANCE:

Name of Insurance Company: _____CLAIMS ADDRESS:_____

EFFECTIVE DATE:_____

SUBSCRIBERS NAME:_____DOB_____SSN#_____

I consent to treatment necessary for the care of the above named patient. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records, if necessary. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. This includes, but is not limited to payments for copays, coinsurance, and deductibles. I understand that if surgery is needed, I will be responsible for paying a surgical deposit 48 hours prior to surgery. I also understand that a charge of $25 will be charged on my account for any short term disability papers or FMLA forms. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to Stephen G. Quill, M.D. should they elect to receive such payment. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

SIGNATURE:_____DATE_____