PATIENT REGISTRATION INFORMATION

NAME _____ **BIRTHDATE** _____**AGE** _____
LAST FIRST M.I.

_____ _____ ____ _____
Address City State Zip Code

PATIENT SS# _____ **HOME PHONE#** (_____)_____

PATIENT CELL# (____)_____ **SPOUSE CELL#** (____)_____

PATIENT EMAIL ADDRESS _____

PATIENT EMPLOYER _____ **EMPLOYER PHONE #** _(_____)_____

SPOUSE NAME _____ **SPOUSE SS#** _____**SPOUSE DOB** _____

NOTIFY IN EMERGENCY _____ **RELATION**_____ **PHONE #**__(____)_____

REFERRED BY _____ **PHONE #** _(_____)_____

PHYSICIAN NAME_____ **PHYSICIAN PHONE #** _(____)_____

INSURANCE INFORMATION

NAME OF INSURANCE CO. _____ **SUBSCRIBER NAME** _____

ID/POLICY # _____ **GROUP #**_____

ADDRESS TO SEND CLAIMS TO: _____

EMPLOYER & ADDRESS _____

EMPLOYER PHONE # _(____)_____ **PRE-CERTIFICATION PHONE #**_(____)_____

PATIENT'S MEDICAL AUTHORIZATION

I request that payment of authorized Medicare or Insurance benefits be made on my behalf to: Dr. Donald deGrange any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to Medicare and its agents or any other secondary insurance, any information needed to determine these benefits or the benefits payable to related services.

I authorize treatment of the person named above. I agree to pay all charges shown by statements promptly. I agree to get all proper referrals that are needed from my primary care physician or insurance company. If I fail to get the proper referrals that are required by my Insurance Company or primary physician, then I will be responsible for all charges incurred until proper authorization is acquired. I understand that I must verify insurance coverage for office visits and for any outpatient treatment prescribed, such as therapy or bracing.

All medical records releases must be requested in writing with a signed authorization by the patient or guardian.

NOTE: Photocopy of this assignment & authorization is to be considered as valid as the original.

SIGNATURE OF PATIENT/PARENT_____**DATE** _____