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#**

UNDER 18 PARENT/GUARDIAN

SPOUSE/SIGNIFICANT OTHER NAME

EMERGENCY CONTACT NAME/ADDRESS

RELATIONSHIP TO PATIENT **PHONE**

PRIMARY CARE PHYSICIAN INFORMATION

NAME

ADDRESS **PHONE** **FAX**

PLEASE LET US KNOW IF YOU WERE REFERRED TO US SO THAT WE MAY THANK THEM:

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of medical benefits to Richard L. VanBuskirk, D.O. for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

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. VanBuskirk, 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**