PATIENT REGISTRATION FORM: **DATE:**

NAME: Marital Status: S M W D SEP

SSN#: DATE OF BIRTH: SEX: M / F

ADDRESS: CITY: STATE: ZIP:

PHONE (H) PHONE (W): CELL:

E-MAIL ADDRESS: (Please print clearly):

EMERGENCY CONTACT: PHONE#:

(OTHER THAN SPOUSE): RELATION:

DRIVER'S LICENSE #: REFERRED BY:

INSURANCE AND BILLING INFORMATION

SUBSCRIBER: RELATION:

SUBSCRIBER'S DOB: PHONE#:

INSURANCE NAME: PHONE#:

INSURANCE ADDRESS:

POLICY ID#; GROUP# EFFECTIVE DATE:

SECONDARY INSURANCE NAME:

SUBSCRIBER'S NAME: SUBSCRIBER'S DOB:

POLICY ID# GROUP# EFFECTIVE DATE:

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dr. CHUKWUEMEKA ONYEWU, 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.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. CHUKWUEMEKA ONYEWU, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

PATIENT (please sign) _____ DATE_____

PATIENT/GUARDIAN (please sign) _____ DATE_____

MEDICARE-MEDICAID

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.
PATIENT (please sign_____ DATE_____