PATIENT REGISTRATION FORM

Today's Date____/____/____

Name _____
Last First MI

Date of Birth ____/____/____ Age_____ Sex_____ Marital Status_____

SSN _____

Mailing Address_____
City State Zip Code

Home Phone (____)_____ Work Phone (____)_____ Cell Phone (____)_____

Employer_____/ Occupation_____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name _____
Last First MI

Address_____
City State Zip Code

Home Phone (____)_____Work Phone (____)_____Cell Phone (____)_____

Date of Birth ____/____/____ Sex_____ SSN _____

INSURANCE INFORMATION (Please present insurance card at time of check in.)

Primary Insurance Name _____

Insurance Address _____

Name of Policy Holder_____

DOB____/____/____SSN of Policy Holder _____

Insurance phone #_____

Insured's ID#_____

Group #_____

Relationship of patient to Policy Holder_____

Secondary Insurance Name _____

Insurance Address _____

Name of Policy Holder_____

DOB____/____/____SSN of Policy Holder _____

Insurance phone #_____

Insured's ID#_____

Group #_____

Relationship of patient to Policy Holder_____

In Case of emergency, person to contact other than spouse_____

Address_____Phone (____)_____

Referring Doctor_____

How may we contact your regarding follow-up, labs or biopsy results, etc.?

Send a message via e-mail? (This includes normal lab results) ❑ YES ❑ NO E-mail:_____

Leave a message on your answering machine at home? ❑ YES ❑ NO _____

May we call you at home? ❑ YES ❑ NO _____

May we call your place of employment? ❑ YES ❑ NO _____

May we call you on your cell phone? ❑ YES ❑ NO _____

Discuss your medical condition with any member of your household? ❑ YES ❑ NO

If yes, whom_____ Relationship_____

I hereby request the professional services of RONALD C. KNIPE, M.D., P.A. and agree to financial responsibility as indicated in the paragraph below:

We only file insurance claims to plans in which we participate. If you are not covered by one of the insurance plans that we participate in, then payment is expected at the time of service. I authorize the release of medical information necessary to process claims and also authorize payment of medical benefits to the physician. If insurance does not pay, I will become financially responsible for payment in full.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN_____**DATE**_____