PATIENT REGISTRATION

NAME_____ DATE OF BIRTH_____ AGE_____

ADDRESS_____

CITY_____ STATE _____ ZIP_____

HOME PHONE_____ CELL PHONE_____

SOCIAL SECURITY #_____ DRIVER'S LICENSE #_____

EMPLOYER _____

OCCUPATION_____

WORK ADDRESS_____

WORK PHONE_____

EMAIL ADDRESS_____

NAME OF SPOUSE OR PARENT (IF MINOR)_____

SPOUSE OR PARENT'S EMPLOYER_____

PHONE_____

WORK ADDRESS_____

REFERRED BY_____ FOR_____

OTHER FAMILY MEMBERS SEEN HERE_____

CONTACT IN CASE OF EMERGENCY_____

INSURANCE ASSIGNMENT AND CONSENT TO RELEASE INFORMATION

INSURANCE COMPANY _____

ADDRESS_____

PHONE NUMBER_____ INSURED'S NAME_____

ID#_____ GROUP #_____ INSURED'S DOB_____

MEDICARE #_____

PERSON RESPONSIBLE FOR THIS ACCOUNT_____

ADDRESS_____

PHONE#_____

I hereby authorize Elvira Klause, M.D. or her staff or biller to furnish information to the above named insurance carrier(s) concerning all treatments and/or visits, and I hereby irrevocably assign to Dr. Klause and staff all payments for medical services rendered. I authorize treatment for the person named herein and understand that I am ultimately responsible for the charges, regardless of available insurance benefits. A Photostat copy of this assignment shall be considered as valid as the original.

_____ _____

INSURED'S SIGNATURE PATIENT'S SIGNATURE