

PATIENT REGISTRATION INFORMATION

Please complete all sections and provide us with a copy of your medical coverage card.

PATIENT INFORMATION

Name _____
(LAST) (FIRST) (INITIAL) (MAIDEN NAME)
Home Address _____
(STREET/APT NO.) (NO P.O. BOX PLEASE) (CITY) (STATE) (ZIP)
Mailing Address _____
Phone#(Home) () E-mail Address _____
May we call to confirm your appointment? Yes No Mobile () _____
Work () _____
Birthdate _____ Age _____ SS# _____
Marital Status: S M D W May we call your home with medical and billing information? Yes No
Your Employer _____ Occupation _____
Work Address _____ Do you have a Living Will? Yes No
Spouse/Other Name: _____ Spouse/Other work/cell number _____

NAME AND ADDRESS OF PERSON NOT LIVING WITH YOU

Name _____
Address _____
Phone# (Home) () (Work) () _____

PRIMARY POLICY HOLDER INFORMATION

Name _____ Self / Spouse / Parent / Other Circle One
Birthdate _____ SS#/ Required _____
Employer _____ Work Phone# () _____
Work Address _____
Insurance Carrier _____ Policy # _____
Claims Mailing Address _____ Group # _____

SECONDARY INSURANCE INFORMATION

Name _____ Self / Spouse / Parent / Other Circle One
Birthdate _____ SS#/ Required _____
Employer _____ Work Phone# () _____
Work Address _____
Insurance Carrier _____ Policy # _____
Claims Mailing Address _____ Group # _____

Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Dr. John T. Schroll and any assisting providers, for services rendered. I understand that copays are due at the time of service and that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall serve as valid as the original.

Your Signature: _____ Date: _____