PATIENT REGISTRATION

PAYMENT REQUIRED AT TIME OF SERVICE: CASH, CHECK, CREDIT OR DEBIT CARDS ACCEPTED.

PATIENTS NAME: ______________________________ DATE OF BIRTH: ______________________

SEX: M F RACE: W B H OTHER MARITAL STATUS: S M D W SEP

PATIENT SOCIAL SECURITY #: __________________ DRIVER'S LICENSE #: ____________________

STREET ADDRESS: ____________________________ CITY: ____________________________
STATE, ZIP: ________________________

MAILING ADDRESS: ___________________________ CITY: ____________________________
STATE, ZIP: ________________________

PHONE: HOME: ______________________________ OCCUPATION: ______________________
NUMBER: WORK: ______________________________ EMPLOYER: ________________________
CELL: ______________________________

SPOUSE/PARENT/GUARDIAN
NAME: ______________________________________ DATE OF BIRTH: ____________________

ADDRESS: ____________________________________ CITY: ____________________________
STATE, ZIP: ________________________
PHONE: HOME: ______________________________ OCCUPATION: ______________________
NUMBER: WORK: ______________________________ EMPLOYER: ________________________

PRIMARY INSURANCE: __________________________ ID #: ______________ GROUP #: ________
ADDRESS: ____________________________________ RELATION TO PATIENT: ________________

SECONDARY INSURANCE: ________________________ ID#: ______________ GROUP #: ________
ADDRESS: ____________________________________ RELATION TO PATIENT: ________________

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE BOHLER FAMILY PRACTICE, PC TO DIRECT PAYMENT FOR ANY SURGICAL AND/OR MEDICAL BENEFITS FOR SERVICES RENDERED. I ALSO HEREBY AUTHORIZE BOHLER FAMILY PRACTICE, PC TO RELEASE ANY MEDICAL INFORMATION THAT MAY BE NECESSARY FOR MEDICAL CARE AND/OR PROCESSING INSURANCE.

PATIENT'S SIGNATURE: ____________________________ DATE: __________________________

PARENT/GUARDIAN SIGNATURE: ______________________ DATE: __________________________