PATIENT REGISTRATION FORM

Patient Name: ______________________________ Social Security Number: ________-________-__________
Date of Birth: _____/_____/_____ Sex: M / F (Circle one) Married/Single/Divorced/Widow
Address:____
(Street) (City/State/Zip)
Email____
Home Phone: (______) _____________-___________Cell Number: ____________________________________
Employer Name: ______________________________Employer Phone Number: (_____) __________________
Employer Address: ____
(Street) (City/State/Zip)
Primary Care Physician: ____ Co-pay Amount $_______________
(Name)
How did you hear about our Practice? ____

Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name: ______________________________________ Social Security Number: _____ - _____ - _____
Relationship to Patient: (please check): ( ) self, ( ) spouse, or ( ) parent Date of Birth: _____/_____/_____
Address: ____
Phone Number: _____________________________Cell Number: _____________________________________
Employer Name: _________________________________ Employer Phone Number: (___) _________________

Who to call for an emergency:

Name: ________________________________ Address:____
Home Phone: (__) _______ - ________ Work Phone: (___) _______-_______ Relationship: ________________

FIRST INSURANCE INFORMATION

Plan Name: _____________________________________ I.D. Number: _______________________________
Address: _______________________________________ Group Number: _____________________________
Policy Holder: __________________________________ Effective Date: ____________________________
Policy Holder's Social Security Number: _________ - ________ - ________
Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

SECOND INSURANCE INFORMATION

Plan Name: _____________________________________ I.D. Number: ______________________________
Address: _______________________________________ Group Number: ____________________________
Policy Holder: __________________________________ Effective Date: ____________________________
Policy Holder's Social Security Number: _________ - ________ - ________
Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

THIRD INSURANCE INFORMATION

Plan Name: _____________________________________ I.D. Number: _____________________________
Address: _______________________________________ Group Number: ___________________________
Policy Holder: __________________________________ Effective Date: ___________________________
Policy Holder's Social Security Number: _________ - ________ - ________
Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Steffen Cameron, MD. I acknowledge that I am financially responsible for payment whether or not covered by insurance.
Signature: ____ Date: ____________________