PATIENT REGISTRATION FORM

Please fill out completely

Mr./Miss/Ms/Mrs. (Please circle one)

NAME_____ _____/_____/_____
First Middle Last Date of Birth

Home Address: _____ _____
Street *Social Security No.*

_____ Sex (please circle) M F
City, State, Zip Code

Home Phone: _____ Work Phone:_____

Pager: _____ Email: _____

Employer: _____ Occupation: _____

Referred by:_____ Primary Care Dr.:_____

Referring Dr. Phone #:_____ Primary Care Dr. Phone #: _____

Part of Body Injured: _____ Date of injury/first symptom:_____

How were you injured?:_____

Have X-rays been taken
Within the past 6 months? Yes___ No ___ If yes, where:_____
Name City State

Emergency Contact: _____ Phone:_____

We require cash payment on the day you are treated, if you are not covered by a current health insurance policy. If you are a member of a health maintenance organization (HMO) or a preferred physician organization (PPO), please give us your insurance card to copy for our files. <u>WE REQUIRE CO-PAYMENT ON THE DAY YOU ARE TREATED.</u>

Insurance Company:_____ Group #:_____

Insurance Company Address: _____

Name of Insured:_____ Insured SS#: _____

Relationship to patient: _____ If applicable, Medicare #:_____

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to Eugene M. Wolf, M.D., the insurance benefits otherwise payable to me. I understand I am financially responsible for the charges not covered by this authorization. I authorize the release of any medical or other information necessary to process the claim. If it becomes necessary for the account to be referred to an attorney for collection of suit, the undersigned shall pay the reasonable attorney's fee and collection expenses.

Payment is required at the time of service, unless other financial arrangements are made in advance.

Signature: _____ Date:_____