PATIENT REGISTRATION FORM

Patient **LEGAL** name _____ SEX: M / F
First Middle Last

BIRTHDATE _____ AGE _____ SSN _____

MARITAL STATUS: Single / Married / Widow / Divorced / Other

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME (____)_____ WORK (_____)_____ CELL (_____)_____

E-MAIL _____

REFERRED BY _____ PRIMARY CARE PHYSICIAN_____

PERSON RESPONSIBLE FOR ACCOUNT _____PHONE (____)_____

PERSON TO NOTIFY IN CASE OF EMERGENCY_____

RELATIONSHIP TO PATIENT_____ PHONE (_____)_____

INSURANCE INFORMATION

NOTES:

INSURANCE ASSIGNMENT AND RELEASE INCLUDING MEDICAL ASSISTANCE

I understand that I am personally liable for any charges not covered by my insurance company, including medical assistance. I also understand that this account and the charges incurred are my responsibility and if my medical coverage is pending, my account will be treated as a self pay account until I produce an active insurance. I hereby authorize **Lance K. Bergstrom, MD Steven B. Thom, MD Nicole M. Collins, OD**; the doctor's billing company or staff to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions either via paper claim or electronically.

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Responsible Party Relationship to Patient Date

MEDICARE AUTHORIZATION

I request the payment of authorized Medicare benefits be made on my behalf for any services furnished to **Lance K. Bergstrom, MD Steven B. Thom, MD Nicole M. Collins, OD** I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If I have a secondary insurance company as I have indicated, my signature authorizes release of the information to the insurer or agency shown whether submitted by paper claim or by electronic means. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge and I understand that I am responsible for any deductible and co-payment amounts. I also understand that some services may not be covered by the Medicare program and that I am responsible for payment of those services.

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Medicare recipient's signature Date Witness Patient's Name (as it appears on Medicare ID card)