

PLEASE PRINT CLEARLY

PATIENT INFORMATION				PATIENT REGISTRATION #							
Last Name		First		Middle		Home Phone ()		<input type="checkbox"/> Male <input type="checkbox"/> Female			
Age	Date of Birth		Marital Status: Married Single Widowed Separated Divorced		Social Security Number		Referring Physician				
Permanent Address		Street		City		State		Zip Code		Cell Number	
Temporary Address		Street		City		State		Zip Code		Work Number	
Patient's Employer		Address							Email Address		
Living Will <input type="checkbox"/> Yes <input type="checkbox"/> No				Power of Attorney <input type="checkbox"/> Yes <input type="checkbox"/> No							
PARENT / GUARDIAN CAN BE CALLED AT WORK FOR NON-EMERGENCIES <input type="checkbox"/> Yes <input type="checkbox"/> No											
Name of Spouse		Employed By							Work Phone		
Nearest Relative not living with you		Address				Rel to Patient		Phone Number			
Emergency contact					Rel to Patient			Phone Number			
Pharmacy Name		Address							Phone Number		
PERSON RESPONSIBLE FOR PAYMENT											
Last Name		First		Middle		Social Security Number		Relationship to patient			
Address		Street		City		State		Zip Code		Phone Number	
Employed by		Address				How long?		Work Phone			
INSURANCE INFORMATION											
First Insurance					Second Insurance						
Name of Insurance Company					Name of Insurance Company						
Address of Insurance Company					Address of Insurance Company						
Policy Holder Subscriber Name			Relationship to patient		Policy Holder Subscriber Name						
DOB	Complete number as stated on card		Group No		Complete number as stated on card		Group No				
Note: Any claim of insurance or group agency coverage must be confirmed by an identification card or letter of authorization form the Company or Agency at the time of visit											
INJURY RELATED INFORMATION											
On Job Injury <input type="checkbox"/> Yes <input type="checkbox"/> No		Auto Injury <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of accident		Attorney involved <input type="checkbox"/> Yes <input type="checkbox"/> No					
Name of Attorney		Address							Phone		
Brief description of accident											

I certify that the information given by me in applying for payment under my insurance contract (including Title XVIII of the Social Security Act) is correct.

I authorize release to my insurance carrier, referring physicians and the respective agents, and to agents of my treating physician, any information needed including diagnosis and records of any treatment or examination rendered to me to process this claim or for purposes of care and treatment, quality assurance or utilization review.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to Osler Medical or authorize Osler Medical to submit a claim to my insurance carrier, including Medicare, for payment to me. I acknowledge that an \$8 service charge may be charged to my account for any managed care co-pays not paid at the time of service.

I understand that I will receive monthly statements, reflecting my account balance and that the FINAL PAYMENT of this account remains my responsibility. A LATE CHARGE of 1½% per month calculated on outstanding balances over 90 days may be applied.

LIFETIME SIGNATURE AUTHORIZATION

This authorization and assignment is to be a continuing one, remaining in force until revoked in writing by the undersigned for services beginning

Date: _____ Signature: _____ Witness: _____