PATIENT REGISTRATION FORM

PLEASE COMPLETE THIS FORM FOR OUR RECORDS			TODAY'S DATE:
PATIENT INFORMATION			
LAST NAME:	FIRST NAME:	M.I.:	DATE OF BIRTH:
STREET ADDRESS:		SEX:	SOCIAL SECURITY #:
CITY:	STATE: ZIP:		CELL PHONE:
OCCUPATION:	EMPLOYER:		HOME PHONE:
EMPLOYER ADDRESS:			WORK PHONE:
NAME OF PRIMARY CARE PHYSICIAN:	PHYSICIAN PHONE:	WHO REFERRED YOU?:	
INSURANCE INFORMATION			
INSURANCE COMPANY:	GROUP NUMBER:	I.D. NUMBER:	
POLICY HOLDER NAME:	RELATIONSHIP TO PATIENT:		
POLICY HOLDER SOCIAL SECURITY #:	POLICY HOLDER DATE OF BIRTH:		
RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)			
LAST NAME:	FIRST NAME:	M.I.:	DATE OF BIRTH:
MAILING ADDRESS:			SOCIAL SECURITY #:
CITY:	STATE: ZIP:		PHONE:
EMERGENCY INFORMATION			
PERSON TO CONTACT IN CASE OF EMERGENCY:		RELATIONSHIP:	
ADDRESS:			PHONE:

INFORMATION FOR THE PATIENT

1. PATIENTS WITH INSURANCE SHOULD REMEMBER THAT PROFESSIONAL SERVICES ARE RENDERED TO THE PATIENT AND NOT TO THE INSURANCE COMPANY. ALL PATIENTS WITH INSURANCE ARE EXPECTED TO MAKE C0-PAY PAYMENTS AT THE TIME OF SERVICE. THE OFFICE WILL FILE INSURANCE CLAIMS TO PRIMARY INSURANCE COMPANIES ONLY. FILING CLAIMS TO ANY SECONDARY INSURANCE IS THE RESPONSIBILITY OF THE PATIENT. PATIENTS WITH INSURANCE WILL RECEIVE A STATEMENT FROM OUR OFFICE AFTER AN "EXPLANATION OF BENEFITS" IS RECEIVED FROM YOUR INSURANCE COMPANY. TIMELY PAYMENT, WITHIN 30 DAYS, OF ANY BALANCE IS THEN REQUIRED.

2. PATIENTS WITHOUT INSURANCE, OR PROOF OF INSURANCE, ARE EXPECTED TO MAKE PAYMENT IN FULL AT TIME OF SERVICE.

3. 24 HOUR NOTICE IS REQUIRED FOR THE CANCELLATION OF ANY APPOINTMENT. A $50 RESCHEDULING FEE IS CHARGED FOR MISSED OFFICE VISIT APPOINTMENTS OR SAME-DAY CANCELLATIONS. A $150 RESCHEDULING FREE IS CHARGED FOR MISSED PROCEDURE/SURGERY APPOINTMENTS OR SAME DAY CANCELLATIONS.

4. A $35 FEE WILL BE CHARGED FOR ANY RETURNED CHECKS. A COLLECTION FEE OF 45% WILL BE ADDED TO ANY OUTSTANDING BALANCE THAT IS REFERRED TO OUR COLLECTION AGENCY. PATIENTS SENT TO COLLECTIONS WILL AUTOMATICALLY BE DISMISSED FROM THE PRACTICE.

5. YOUR SIGNATURE BELOW AUTHORIZES PAYMENT OF MEDICAL BENEFITS TO DAVID S PEZEN, MD, SC FOR MEDICAL SERVICES RENDERED AND SIGNIFIES YOUR WILLINGNESS TO COMPLY WITH THE ABOVE MENTIONED POLICIES.

SIGNATURE:	DATE: