Patient Registration (Please Print)

Patient Name_____ Today's Date ___/___/_____
Last First MI

Date of Birth _____/_____/_____ Age_____ ___Male ___Female Marital Status: __S __M __W __D

Address_____
Street Apt/Unit/Lot City State Zip

Patient S.S. No. _____ Employer _____ Occupation_____

Home Telephone: (___)_____ Cell Phone: (___)_____ Work Phone (___)_____
What number would you prefer us to use to contact you? ___Home ___Cell ___Work

Living Will / Advanced Directives

I have a Living Will / Advanced Directives __Yes __No If yes, please provide a copy to the office.

Emergency Contact Information / Permission to Release Information

*I authorize Dr's Stine, Dean, Okeson or Howard to discuss my healthcare (including test results) with the emergency contact person(s) listed below:

Name_____Relationship_____Phone (___)_____

Name_____Relationship_____Phone (___)_____

Name_____Relationship_____Phone (___)_____

*I understand that this permission to release will expire one year from the date I sign it. _____(initial)

Insurance / Payment Information

Please present your insurance card to the Receptionist

Primary Health Ins Company _____
Policy Holder's Name _____Policy Holder's DOB _____
Policy Holder's Relationship To Patient _____Policy Holder's Employer_____

Secondary Health Ins Company _____
Policy Holder's Name_____ Policy Holder's DOB_____
Policy Holder's Relationship To Patient _____Policy Holder's Employer_____

Person financially responsible for this account _____Relationship to patient _____

1. I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services, copays, co-insurance or deductibles. **2**. I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims. **3**. I acknowledge I have received a copy of the notice of HIPAA policies for this office.

_____ _____
Signature (Patient or Parent/Guardian if Minor) Date