



PATIENT REGISTRATION FORM

Please print when completing this form. As a reminder, all information is confidential.

Today's Date: _____ SSN: _____

Patient Name: _____ Birth Date: _____

Address _____ Male: _____ Female: _____

City, State, Zip _____ Marital Status: _____ Married _____ Single

Home Phone: _____ Cell Phone: _____ _____ Divorced _____ Separated

Email: _____ _____ Widow _____ Partner

May we send you information by e-mail? Yes No

Patient or Parent's Employer _____ Work Phone: _____

If patient is a student, name of school/college: _____

How were you referred to us: Please check all that apply

Internet _____ Radio Station _____ Name Station _____ Other _____

Google _____ Patient _____ Patient's Name _____

Sign on Building _____ Doctor _____ Doctor's Name _____

Magazine _____ Word of Mouth _____ Please circle: friend | relative | employee | hospital staff

Yellow Pages _____ Internet Site _____ Name of Site _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Responsible Party Information Person responsible for this account: _____ Relationship to patient: _____ Home Phone: _____

Address: _____ City, State, Zip: _____

Driver's License Number _____ Birth Date: _____

Employer: _____ Work Phone: _____ Is this person currently a patient at our office? Yes No

Insurance Information Name of insurance company: _____ (A copy of card will be made)

Policyholder's name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Notice of Privacy Practice I consent for Dr. Jeffrey Ditesheim to use and disclose protected health information for treatment, payment and healthcare operations. I have ready a copy of Dr. Ditesheim's Notice of Privacy Practices (HIPAA) and consent to all disclosures.

Patient or Legal Guardian Signature: _____ Date _____

Assignment Of Benefits I authorize payments to Dr. Jeffrey Ditesheim of any benefits which would otherwise be payable to me and which were established by my insurance company. I understand that I am responsible for the payment of charges which are not paid by my insurance company.

Patient or Legal Guardian Signature: _____ Date _____