

PATIENT REGISTRATION FORM

PATIENT NAME:	S.S. #	BIRTH DATE:	AGE:	MARITAL STATUS: S M W D SEP	SEX: M F
STREET ADDRESS :		CITY:	STATE:	ZIP CODE:	PHONE # :
PATIENT OR PARENT EMPLOYER :			BUSINESS PHONE :		HOW LONG EMPLOYED :
EMPLOYER ADDRESS :		CITY:	STATE:	ZIP CODE:	
SPOUSE OR PARENT'S NAME:		S.S#	BIRTH DATE:	HOME PHONE #:	BUS. PHONE #:
SPOUSE'S OR PARENT'S EMPLOYER:					
SPOUSE'S OR PARENT'S EMPLOYER STREET ADDRESS:		CITY:	STATE:	ZIP CODE:	
PATIENT OCCUPATION (INDICATE IF STUDENT) :			SPOUSE OR PARENT'S OCCUPATION:		

AUTHORIZATION TO RELEASE AND ASSIGN BENEFITS AND ACCEPT FINANCIAL RESPONSIBILITY

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with business office.

I request that payment of authorized Medicare/Other insurance company benefits be made either to me or on my behalf to **Kathy L. P. Cook, M.D.** for any services furnished me by that party who accepts assignment/clinician Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

Signature:

Date: