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DEBORAH J. FREEHLING, M.D., Inc.

Patient Registration Form

Date:

PATIENT INFORMATION (PLEASE PRINT CLEARLY) ___ New Patient ___ Update

NAME _____
Last **First** **MI**

ADDRESS _____

CITY, STATE, ZIP _____

HOME # (___) _____

WORK # (____) _____

CELL # (____) _____

Email _____

Social Security _____-_____-_____

BIRTHDAY _____/_____/_____ AGE _____

____ MALE ___ FEMALE RACE _____ (OPTIONAL)

MARITAL STATUS:

____ SINGLE ___MARRIED ___WIDOWED

___ DIVORCED ___ SEPARATED

Driver's License ID#: _____

EMERGENCY ALTERNATE: **PERSON NOT LIVING WITH YOU**

NAME _____

PHONE # (___) _____

REFERRING DOCTOR OR SOURCE:

NAME _____

ADDRESS _____ CITY _____

PHONE # (___) _____ ZIP _____

RESPONSIBLE PARTY INFORMATION (Subscriber Information)

NAME _____
Last **First** **MI**

ADDRESS _____

CITY, STATE, ZIP _____

HOME # (____) _____

WORK# (____) _____ EXT ____

BIRTHDAY _____/_____/_____ AGE _____

Social Security _____-_____-_____

EMPLOYER _____

ADDRESS _____

CITY, STATE, ZIP _____

Email _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is the patient's responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by the patient's insurance.

In order to control costs of billing, we request that our charges for office visits be paid at the conclusion of each visit. (Excluding PPOs and other insurance companies with which we have previous arrangements).

For PPOs and other insurance companies with which this physician has made arrangements, I hereby assign all medical and/or surgical benefits including major medical benefits to which I may be entitled, including private insurance and other health plans to Deborah Freehling, M.D. for services billed by her office.

The assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

(Updated 12/2010)

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SIGNED (Patient, or parent if under 18 years of age) Date