Patient Registration Information

Last Name________________________________ First Name_________________________ MI______

Address________________________________ Apt.______ City_____________ State_____ Zip______

Home Phone___________________ Cell Phone ________________ Email_______________________

Sex______ Date of Birth__________

Employer____________________________ Employer's Address________________________________

If the patient is a minor/dependant, please complete the following:

Legal Guardian/Parent___________________________________ Relation to patient________________

Address____ Phone_________________________

Primary Insurance (a copy of your insurance card is required)

Insurance__________________________ ID#_____________________ Group #__________________

Insured's Name____D.O.B____________________

Relation to patient____ SSN ________________________

Employer's Name____

Secondary Insurance (a copy of your insurance card is required)

Insurance__________________________ ID#_____________________ Group #__________________

Insured's Name____D.O.B____________________

Relation to patient____ SSN ________________________

Employer's Name____

Emergency Contact

Name__________________________________Address_______________________________________

Home phone____________________________ Cell phone____________________________________

Work phone_____________________________ Employer____________________________________

ASSIGNMENT AND RELEASE

Authorization to treat and release information to insurance carrier for direct payment to the provider (Cary B. Chapman, MD, PLLC).
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. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I authorize any holder of medical or other information about me to release to my insurance company or to the Social Security Administration any information needed for this or any related claim. I permit and request payment of medical benefits either to myself or to the party who accepts assignment. Regulations pertaining to the assignment of benefits apply. I understand that I am obligated to pay any charges deemed medically unnecessary or classified non-covered by Medicare.

Print Name____________________________________ Signature_______________________________

Date___________________________

If patient is minor or unable to sign

Guardian_____________________________________ Signature_______________________________