Patient Registration

Please Print *Referred By:* _____

PATIENT: THIS SECTION REFERS TO PATIENT ONLY

Last First M.I.

Name:

Address:

City: State: ZIP:

Birthdate	Sex	Age

Marital Status (X One)

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Home Ph: ( ) Work Ph: ( )

SS # CALLS OK?

Employer:

Address:

City: State: ZIP:

Occupation:

BILLING: Please complete if person responsible for bill is other than above patient.

Name:

Address:

City: State: ZIP:

Home Phone ( )

Work Phone ( )

Patient's Relationship to Patient	SS #

Occupation:

Employer:

Address:

City: State: ZIP:

INSURANCE INFORMATION

Please give us all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, supply information on both carriers. Please list all numbers on your card(s). Please check your insurance policy for a waiting period before coverage or pre-existing clauses. IF YOUR COVERAGE IS CONTINGENT ON A SECOND OPINION OR PRE-ADMISSION APPROVAL, IT IS YOUR RESPONSIBILITY TO INFORM US.

Primary Carrier Name:

Insured ID No.:

Insured:

Name on ID Card:

Patient's Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Address:

Secondary Carrier Name:

Insured ID No.:

Insured:

Name on ID Card:

Patient's Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Address:

In case of an emergency please notify:

Name: Relationship: Phone:

AUTHORIZATION

INSURANCE and HEALTHCARE AFFILITATES

I hereby authorize release of medical records and information necessary to file a claim or to render services and treatment with my insurance company and healthcare and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME AND TO THE DOCTOR INDICATED ON THE CLAIM.
I understand I am financially responsible for any balance not covered by my insurance carrier.
A copy of this signature is a valid as the original without expiration unless indicated by myself in writing.

MEDICARE

I request that payment of authorized Medicare benefits be made either to me or on behalf to Kevin Christensen, M.D., Inc. for any services furnished by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.
I understand my signature requests that payment be made and authorizes releases of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of HCFA-1400 form or elsewhere on other approved claim forms or electronically submitted claim, my signature authorizes releasing the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Date: Signature