Practice Name: Richard Shebelut, M.D.

PATIENT REGISTRATION FORM (Please print)

Patient Demographics

First Name:	______	**SSN:**	____ — ____ — ____
Last Name:	______	**Age:**	Yrs ____ Mo ____
Date of Birth:	______	**Sex:**	Male Female
Home Address	______	**Marital Status:**	Single Married Widowed Divorced
City, State, Zip	______	**Employer:**	______
Home Phone:	______	**Occupation:**	______
Cell Phone:	______	**Work Address:**	______
Email:	______	**Work Phone:**	______
Emergency Contact Name & Relation:		**Emergency Phone (diff. than home):**	

Responsible Party Info (if other than patient)

First Name:	______	**SSN:**	____ — ____ — ____
Last Name:	______	**Age:**	Yrs ____ Mo ____
Date of Birth:	______	**Sex:**	Male Female
Home Address	______	**Employer:**	______
City, State, Zip	______	**Occupation:**	______
Home Phone:	______	**Work Address:**	______
Cell Phone:	______	**Work Phone:**	______
Relation to Patient:			

Insurance Information

Primary Insurance Name:	______	**Ins. Card Provided:**	Yes No
Subscriber Name:	______	**Subscriber ID:**	______
Insurance Address:	______	**Group ID:**	______
Subscriber DOB:		**PCP Assigned:**	
Secondary Insurance Name:	______	**Ins. Card Provided:**	Yes No
Subscriber Name:	______	**Subscriber ID:**	______
Insurance Address:	______	**Group ID:**	______
Subscriber DOB:		**PCP Assigned:**	

Consent for Treatment

I hereby give consent for medical or surgical treatment to the attending physician to care for myself or I am duly authorized by the patient as his/her general agent to give consent for such treatment. I hereby give consent for release of medical information to consulting physicians and other medical personnel, as may be required in the rendering of treatment, until I revoke this acknowledgment in writing.

Financial Respons.

I hereby authorize payment directly to the attending physician of any medical/surgical benefits payable to me under the conditions of my policy for services rendered. I hereby give consent for release to authorized person(s) of financial and medical information concerning care, treatments, and charges as may be required to complete all claims for benefits. I understand that I am financially responsible to the above-named office for the services rendered. In the event of collection action, I shall be responsible for any legal fees incurred. I am aware all co-payment amounts are due at the time of visit and must be paid prior to services rendered. I am aware that I am personally responsible for any and all charges for services not covered under my insurance plan, or deductibles/co-insurance amounts that are due prior to active coverage. I understand that I am financially responsible for any and all costs related to laboratory tests, as part of my medical care, that are rendered and not covered by my current insurance plan. I understand a bill will be issued to me for payment on any unpaid/uncovered services.

Notice of Privacy Practice

By signing this form I acknowledge I have been given the opportunity to read the Notice of Privacy Practices Policy in its entirety, and been offered a copy of the document. Furthermore, I recognize and understand my rights and the ways my protected health information may or may not be used and/or disclosed in relation to my healthcare and services received.

How did you hear about our office?	**Health Fair**	**Friend or Family**	**Insurance Assignment**	**Online Search**	**Referral**	**If Referred, who were you referred by?** ______
Circle your preferred method of contact	**Text**	**Voicecall**	**Email**	**Post Mail**		

______ **Patient/Responsible Party Signature**

______ **Date**

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