FOR INSURANCE CLIENTS ONLY

PATIENT REGISTRATION FORM

First Name:_____ Last Name:_____ Middle Initial:_____

Address:_____ City:_____ St:_____ Zip_____

Home Telephone #:_____Alternate Phone#:_____

Date of Birth:___/____/_____ Social security Number:_____-____-_____ Sex:_____

Marital Status: _____ Age_____

Responsible party:_____ Relationship:_____

Occupation:_____ Work Telephone:_____

Employer:_____

Patient/spouse/ or parent (if minor):_____ Telephone #_____

Emergency Contact:_____ Telephone #_____

I authorize the release of medical information necessary to process any of my insurance claims and I authorize payment of medical benefits directly to David A. Fohrman M.D. for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. I am aware that I will be charged the insurance allowable rate, or standard fee if private pay, for any missed appointments which are not rescheduled or cancelled within 24 hours of the scheduled appointment time. The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian, or patient that in considerations of the services to be rendered to the patient, he/she herby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection the undersigned shall pay reasonable attorney's fee and collection expenses.

Name:_____ Signature:_____Date:_____

(over)

Insurance information:

Company Name_____ Policy #:_____

Group #:_____

Policy Holder (if different from patient):_____

Relationship:_____

Policy Holder address:_____

Policy Holder date of birth:_____

Policy Holder phone number:_____