

**Dr. Julie Schneider**  
335 Clyde Morris Boulevard, Suite 240  
Ormond Beach, FL 32174  
Tel: 386-231-6172 / FAX 386-676-6173

**PATIENT REGISTRATION FORM**

**PATIENT INFORMATION:**

**NAME**  
First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Race \_\_\_\_\_ Language \_\_\_\_\_ Ethnicity \_\_\_\_\_

**RESPONSIBLE PARTY – ONLY IF NOT PATIENT:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**EMPLOYMENT INFORMATION:**

Employer: \_\_\_\_\_ Office Phone # \_\_\_\_\_

Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

**PRIMARY INSURANCE:**

Company: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Claims Address: \_\_\_\_\_ Insured DOB: \_\_\_\_\_

Phone #: \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

**SECONDARY INSURANCE (IF APPLICABLE)**

Company: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Claims Address: \_\_\_\_\_ Insured DOB: \_\_\_\_\_

Phone #: \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

**EMERGENCY NOTIFICATION / NEXT OF KIN**

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF PERSONAL MEDICAL INFORMATION:**

I understand, as outlined in the HIPAA Notice of Patient Privacy Practices, my personal medical information will only be released as it pertains to my medical treatment, payment of charges, or operation of the practice and/or hospital. The practice is also authorized to release my personal medical information to the following individual (s):

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS:**

I authorize the release of any medical information necessary to process my insurance claim. I authorize and request payment of medical benefits directly to my physician. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I understand and agree that, regardless of my insurance status, I am responsible for any balance of my account.

\_\_\_\_\_  
Patient Signature or Responsible Party Signature

\_\_\_\_\_  
Date