



DR. Julie Schneider, MD

PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Name: _____ DOB: _____ SS#: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Telephone #: _____

Cell Phone (Alt. #): _____ Marital Status: _____ Sex: _____

RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT):

____ check here if same as patient

Name: _____ DOB: _____ SS#: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Telephone #: _____

Cell Phone (Alt. #): _____ Marital Status: _____ Sex: _____

Relationship to Patient: _____

PRIMARY INSURANCE:

Company: _____ Insured Name: _____

Insured DOB: _____ ID #: _____

Insured party's relationship to patient: _____

SECONDARY INSURANCE:

Company: _____ Insured Name: _____

Insured DOB: _____ ID #: _____

Insured party's relationship to patient: _____

EMPLOYMENT INFORMATION:

Employer: _____

Office Phone #: _____ Occupation: _____

PHARMACY

Name: _____ Phone: _____

PLEASE LIST TREATING DOCTORS: (name & phone numbers)

Primary Care: _____

Referring Physician: _____

Specialist Name/Specialty: _____

EMERGENCY CONTACT/NEXT OF KIN - *SOMEONE NOT IN SAME HOUSEHOLD:*

Name: _____ Relationship to Patient: _____

Telephone Number: _____ Alt. Number: _____

Address: _____

City: _____ State: _____ Zip: _____

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 physicians. 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 Responsibility Party Signature

Date