

PATIENT REGISTRATION

PERSONAL INFORMATION

Patient's Name _____ Home Phone _____

Parent's Name (minors only) _____ Cell Phone _____

Street Address _____ Email Address _____

City, State, Zip _____ Social Security # _____

Birth Date _____ Marital Status S M D W Sex M F

Family Doctor _____

Referring Doctor _____ Do you have a referral for today? Y N

Reason for visit _____

May we leave voice mails at the above telephone numbers? YES / NO If so, which? Home Cell

May we send you emails (i.e. appointment reminders, product and services offerings)? _____

WHERE DID YOU HEAR ABOUT US (Circle one or more):

YELLOW PAGES ER PHYSICIAN FRIEND PATIENT SEMINAR DE TODAY WEBSITE OTHER

EMPLOYMENT INFORMATION

Employer _____ Phone _____

Street Address _____ City, State, Zip _____

HEALTH INSURANCE INFORMATION

Insurance Company _____ Identification # _____

Subscriber's Name _____ Subscriber Date of Birth _____

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. J. Joseph Danyo for any services furnished me by that physician or 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 for related services.

Signature _____ Date _____

IF YOUR INJURIES OCCURRED AT WORK OR IN AN AUTOMOBILE ACCIDENT YOU MUST COMPLETE THE FOLLOWING OR YOU WILL BE BILLED FOR THESE SERVICES

Insurance Company _____ Identification # _____

Address _____ Phone # _____

Claim Number _____ Claim Adjustor _____

I request that payment of authorized insurance benefits be made either to me or on my behalf to Dr. J. Joseph Danyo I authorize any holder of medical information about me to release any said information needed to facilitate payment for related services.

Signature _____ Date _____