



Patient Registration and Health Questionnaire

PAYMENT REQUIRED AT TIME OF SERVICE - UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE

PATIENT INFORMATION

Last Name				First Name				MI	
Street Address				Apt/Suite No.					
City				State		Zip Code			
Home Phone		Cell Phone		Work Phone					
Date of Birth (Mo/Day /Year)			Social Security Number			Driver License No..		State	
Employment Status		Gender	Military	Marital Status		Type of Residence		Student Status	
<input type="checkbox"/> Unemployed		<input type="checkbox"/> Male	<input type="checkbox"/> Active	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Private	<input type="checkbox"/> Residential	<input type="checkbox"/> Full-Time	
<input type="checkbox"/> Employed		<input type="checkbox"/> Female	<input type="checkbox"/> Retired	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	<input type="checkbox"/> Rehab	<input type="checkbox"/> Skilled Nursing	<input type="checkbox"/> Part-Time	
			<input type="checkbox"/> N/A	<input type="checkbox"/> Other	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> N/A			

Parent, Guardian, or Emergency Contact :

Name	Phone
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INSURANCE AND BILLING INFORMATION

Name of PRIMARY Insurance Company

Member ID No.	Group ID.	Insurance Company Phone No.

Last Name of Insured (if different from patient) First Name of Insured MI

Date of Birth (Mo/Day /Year) Social Security Number Driver License No.. State

Relationship to Patient Self Spouse Parent/Guardian Other _____

BILLING ADDRESS (if different from above)

Address City State Zip Code

Name of SECONDARY Insurance Company

Member ID No.	Group ID.	Insurance Company Phone No.

Last Name of Insured (if different from patient) First Name of Insured MI

Date of Birth (Mo/Day /Year) Social Security Number Driver License No.. State

Relationship to Patient Self Spouse Parent/Guardian Other _____

BILLING ADDRESS (if different from above)

Address City State Zip Code

Fee for Service: I understand that payment is required at time of service, unless prior arrangements have been made. **Assignment of Insurance Benefits:** I hereby authorize direct payment of surgical/medical benefits to Dr. Astrid Gutschmann for P.A. for services rendered while under their supervision. I understand that I am financially responsible for any balance not covered by my insurance. **Medicare-Medicaid:** I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be as valid as the original.

PATIENT NAME (please print) _____ **DATE** _____

PARENT / GUARDIAN (please print) _____ **SIGNATURE** _____