LESLIE SHAWN, D.O.

REGISTRATION INFORMATION

(PLEASE PRINT)

Date_____ Home Phone_____

Patient_____
Last Name First Name Initial

Responsible Party (if a minor)_____

Street Address_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ Employed ☐ Full-Time Student ☐ Part-Time Student Patient's School Name_____

Patient Employed By_____

Business Address_____

Occupation_____ Business Phone_____

Spouse (or responsible party) Name_____ Birthdate_____

Business Name and Address_____

Occupation_____ Business Phone_____

Who is responsible for this account?_____ Relationship to Patient_____

Social Security #_____ Spouse's Social Security #_____

Do you have Medical Insurance? ☐ No ☐ Yes If yes,

Name of Primary Insurer_____

Contract #_____ Group #_____ Subscriber #_____

Name of Secondary Insurer (if any)_____

Contract #_____ Group #_____ Subscriber #_____

Are you covered under any of these programs? ☐ Medicare ☐ Medicaid ☐ CHAMPUS ☐ CHAMPVA

☐ Worker Compensation ☐ FECA Black Lung I.D. # for program you've checked_____

If Welfare, your number_____ County of_____

Is your condition related to employment (current or previous) ☐ No ☐ Yes

Is your condition related to auto accident? ☐ No ☐ Yes In which state?_____

Other Accident? ☐ No ☐ Yes Please describe_____

In case of emergency, who should be notified?_____

Phone_____ Relationship to patient_____

(OVER)

Please list other doctors you have seen in the past 5 years:

1._____ City/State_____
(General Practitioner, Specialist, or other)

Reason for seeing_____

2._____ City/State_____
(General Practitioner, Specialist, or other)

Reason for seeing_____

How did you learn of our practice?_____

Whom may we thank for referring you?_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

and assign directly to Dr._____all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr._____ for any services furnished me by that physician. 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. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

OFFICE NOTES

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