

**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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