Marilyn K. Kosier, M.D., Inc. Patient Registration Form

NAME

SOCIAL SECURITY #

BIRTHDATE

STREET

CITY

STATE ZIP

EMAIL

MARITAL STATUS

HOME PHONE ( )

WORK PHONE ( )

CELL PHONE ( )

EMPLOYER

FAMILY DR

OPTOMETRIST

HOW DID YOU HEAR ABOUT US

INSURANCE #1

SUBSCRIBER

BIRTHDATE

SOCIAL SECURITY #

INSURANCE #2

SUBSCRIBER

BIRTHDATE

SOCIAL SECURITY #

EMERGENCY CONTACT NOT IN HOUSEHOLD

NAME

PHONE # ( )

RELATIONSHIP TO PATIENT

PLEASE LIST NAMES OF INDIVIDUALS WE CAN SHARE MEDICAL INFORMATION WITH

NAME

NAME

IF WE REACH YOUR ANSWERING MACHINE OR VOICEMAIL WHEN CALLING WITH DETAILED MEDICAL INFORMATION, IS IT OKAY TO LEAVE A MESSAGE? YES NO

LIST ANY SPECIAL INSTRUCTIONS FOR COMMUNICATING WITH YOU

Assignment of Benefits and Statement of Financial Responsibility

I hereby authorize payment of medical and surgical benefits directly to Marilyn K Kosier, M.D., Inc. I hereby authorize release of all information pertaining to my medical records to Medicare and/or my private insurance. In addition, I have read and understand the Financial Policies for Marilyn K. Kosier, M.D., Inc. All medical and surgical charges incurred by me or my dependents for services rendered by Marilyn K. Kosier, M.D., Inc. are my financial responsibility. This includes co-pays, deductibles and non-covered services. Any fees necessary to collect on this account are payable by me.

Signed Date