Dr. C. S. Michael
REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status (circle one)
			Single / Mar / Div / Sep / Wid
Street address:			Birth date:
			/ /
			Social Security no.:
City:		State:	ZIP Code:
Sex:	Home phone no.:	Work phone no.:	Cell phone no.:
❑ M ❑ F			
Employer:			

PERSON RESPONSIBLE FOR BILL (IF NOT SELF)

Name:		Relationship to patient:	
Address:		Home phone no.:	Work phone no.:
City:	State:	ZIP Code:	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

PRIMARY INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Subscriber's name (if not self):	Subscriber's birth date:	Subscriber's Social Security no.:
	/ /	

Insurance carrier:	Group no.:	Member ID:	Patient's relationship to subscriber:

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Subscriber's name (if not self):	Subscriber's birth date:	Subscriber's Social Security no.:
	/ /	

Insurance carrier:	Group no.:	Member ID:	Patient's relationship to subscriber:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance, including the charge for procedures not covered by my insurance carrier. I also authorize the physician or the insurance company to release any information required to process my claims.

Patient/Guardian signature:	*Date:*