Date: ____________________

Patient Registration

○ New Patient ○ Update Info

Please PRINT and complete ALL sections below!

PATIENT'S PERSONAL INFORMATION

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

Last Name: ______________ First Name: ______________ Initial: ________

Street Address: ______________ Apt. #: ______ City: ______________ State: ________ Zip: ________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Date of Birth: ______________ Driver's License + (State): ______________

Employer/Name of School: ______________ ○ Full Time ○ Part Time

Spouse's Last Name: ______________ First Name: ______________ Initial: ________

Spouse Work Phone: ______________

E-mail: ______________

How Do You Wish To Be Addressed?

PATIENT/RESPONSIBLE PARTY INFORMATION

Responsible Party: ______________ Date of Birth: ______________

Relationship to Patient: ○ Self ○ Spouse ○ Other: ______________

Responsible Party's Home Phone: ______________ Work Phone: ______________

Address: ______________ Apt. #: ______ City: ______________ State: ________ Zip: ________

Employer's Name: ______________ Phone: ______________

Address: ______________ Apt. #: ______ City: ______________ State: ________ Zip: ________

Your Occupation:

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist

PRIMARY Insurance Company's Name: ______________

Insurance Address: ______________ Apt. #: ______ City: ______________ State: ________ Zip: ________

Name of Insured: ______________ Date of Birth: ______________

Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other ______________

Insurance ID Number: ______________ Group Number: ______________

SECONDARY Insurance Company's Name: ______________

Insurance Address: ______________ Apt. #: ______ City: ______________ State: ________ Zip: ________

Name of Insured: ______________ Date of Birth: ______________

Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other ______________

Insurance ID Number: ______________ Group Number: ______________

Check if appropriate: ○ Medigap Policy ○ Retiree Coverage

ASSIGNMENT OF BENEFITS • FINANCIAL AGREEMENT

I hereby give lifetime authorization for payment of insurance benefits to be paid directly to Stefanie Mikulics, MD and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this health care rovider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Your Signature: ______________

PATIENT'S REFERRAL INFORMATION

Referred By: ______________ If referred by a friend, may we thank him or her? ○ Yes ○ No

Name(s) of other physicians who care for you: ______________

EMERGENCY CONTACT

Name of person NOT living with you: ______________

Address: ______________ Apt. #: ______ City: ______________ State: ________ Zip: ________

Home Phone #: ______________ Work Phone #: ______________

May our staff leave messages on your home answering machine? ○ Yes ○ No

May our staff leave messages with a family member?

○ Yes ○ No Who? ______________

May our staff call or leave messages with your listed work number? ○ Yes ○ No

I, ______________ have received a copy of Stefanie Mikulics, MD Notice of Privacy Practices.

______________ ______________

Signature of Patient or Legal Guardian Date