Banister-Lieblong Clinic

Patient Registration

All sections must be completed

Patient Name:_____ Date of Birth:_____

Address (Apt) :_____City:_____ State:_____Zip:_____

Email Address:_____

Social Security Number:_____ Employer:_____

Sex: M F /Marital Status: Single Married Widow /Race:_____

Home Phone:_____Work:_____Cell:_____

If minor, Parent/Legal Guardian name:_____ Second Parent:_____

Emergency Contact Information

Name:_____ Phone:_____

Address (Apt) :_____City:_____ State:_____Zip:_____

Relationship to Patient:_____

Insurance Information

Primary Insurance	Secondary Insurance
Policy Holder:_____	Policy Holder_____
Policy Holder DOB:_____	Policy Holder DOB:_____
Insurance Company:_____	Insurance Company:_____
Address:_____	Address:_____
Effective Date:_____	Effective Date:_____
ID Number:_____	ID Number:_____
Group Number:_____	Group Number:_____

I authorize treatment of the above patient.

I authorize the release of the medical records necessary to process insurance claims.

I am responsible to pay for all services received, regardless of insurance coverage.

I authorize payment of medical benefits to be made directly to Banister-Lieblong Clinic.

I authorize the release of correspondence and/or medical records to other medical providers involved in my care.

I have read and understood the financial policy.

Signature:_____ Date:_____