Registration Form

Michael D. Randell, M.D., F.A.C.O.G.

DATE _____

PATIENT INFORMATION

Name _____
Last Name First Name Middle Name Maiden Name

Address _____ Home Phone _____
Street City & State Zip Code

Fax _____ Pager _____ Mobile Phone _____ E-Mail _____

Birthdate _____ Age _____ Marital Status S M W D SS# _____

Employed By _____ Occupation _____ Work Phone _____

Address _____
Street City & State Zip Code

Spouse's Name _____ Spouse's SS# _____

Spouse's Employer _____ Spouse's Work Phone _____

In Case of Emergency Contact _____ Phone Number _____

Referred By _____

Name & Phone Number of Nearest Relative Not Living With You _____

INFORMATION ON PERSON RESPONSIBLE FOR BILL

Guarantor Name _____

Address _____
Street City & State Zip Code

Home Phone No. _____ Work Phone No. _____

Employed By _____ How Long? _____ Occupation _____

SS # _____ Relationship to Patient _____

INSURANCE INFORMATION

Do you have insurance to cover the fees for services rendered? ❑ Yes ❑ No

PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Insured	Name of Insured
Primary Insurance	Secondary Insurance
Primary Insurance Address	Secondary Insurance Address
Identification #	Identification #
Group # Effective Date	Group # Effective Date
Insured's Date of Birth	Insured's Date of Birth

AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical information necessary to process this claim. Additionally, I request payment (if applicable) of my Medicare benefits either to myself or to the party who accepts assignment.

_____
Signed Date

I authorize payment of medical benefits to Michael D. Randell, M.D. for services performed. I understand that I am responsible for payment regardless of insurance coverage

_____
Signed Date