Richard A. Burgett, M.D., F.A.C.S.
Thomas A. Ciulla, M.D.
Robert D. Deitch, M.D.
Kathryn M. Haider, M.D.
Scott R. Hobson, M.D., F.A.C.S.
Nicholas F. Hrisomalos, M.D.
Stephen M. Johnson, M.D.
Ronald T. Martin, M.D., F.A.C.S.
Raj K. Maturi, M.D.

PATIENT REGISTRATION UPDATE

John T. Minturn, M.D.
Daniel E. Neely, M.D.
Hemang C. Patel, M.D.
David A. Plager, M.D.
Gavin J. Roberts, M.D.
Milan Shah, M.D.
Derek T. Sprunger, M.D.
Robert M. Troyer, M.D.
Michael G. Welsh, M.D., F.A.C.S.

Patient Name: _____ **Date:** _____

Date of Birth: _____ (mm/dd/yyyy) Age:_____ Social Security #: _____ (xxx-xx-xxxx)

Current Address: _____Apt #: _____City: _____State: ____ Zip: _____

Employer Name: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Mobile: (_____) _____

Email Address: _____

Preferred Method of Phone Contact: ☐ Mobile ☐ Home ☐ Work (please check one)

MEDICAL INSURANCE INFORMATION

Primary Insurance Carrier: _____

Secondary Insurance Carrier: _____

We will need to make a copy of your current insurance cards

How is the "Insured" party related: ☐ Self ☐ Guarantor ☐ Spouse

Spouse's Name: _____ Date of Birth: _____ (mm/dd/yyyy) Social Security #: _____ (xxx-xx-xxxx)

Does your insurance company require a formal authorization or referral from a Primary Care Physician for our services?

☐ Yes ☐ No If Yes, Physician's Name: _____

PRIMARY CARE PHYSICIAN

Have you changed Primary Care Physician? ☐ Yes ☐ No

If Yes, Physician's Name: _____Phone #: (_____) _____

Primary Care Physician's Address:_____ City: _____State: ____ Zip: _____

Preferred Pharmacy Name: _____ Phone #: (_____) _____

Preferred Pharmacy Address: _____ City: _____State: ____ Zip: _____

PATIENT REGISTRATION UPDATE CONTINUED

RELEASE OF INFORMATION

I authorize the release of any medical information necessary to my insurance company relative to services rendered. I further authorize the Payment of Benefits to the Physician for services rendered. I understand that this authorization remains valid unless/until I revoke it myself.

X _____ Date: _____

Signature of Patient or Legal Guardian

FINANCIAL RESPONSIBILITY STATEMENT

I acknowledge responsibility for payment of all medical fees regardless of insurance I may have to assist me in this responsibility. The only exception will be charges for services covered under a contractual agreement that has been entered into between my physician and an insurance company, or other third party payor. If for any reason my account should become delinquent, I am liable to pay all collection and legal fees.

X _____ Date: _____

Signature of Patient or Legal Guardian