

PATIENT REGISTRATION

DATE: _____ ACCT#: _____
Hospital Medical Record # _____

Name: _____ Date of Birth: _____ Age: _____

Address: _____
Street Town State ZIP

Social Security #: _____

Home Phone #: _____ Cell Phone #: _____

Employer: _____ Work Phone #: _____

Spouse Name: _____ Spouse Employer: _____

Emergency Contact: _____ Phone #: _____

IF PATIENT IS UNDER AGE 18 – RESPONSIBLE PARTY _____

Marital Status ___Single, ___Married, ___Divorced, ___Widowed. SEX: __Male __Female

INSURANCE INFORMATION: DATE OF BIRTH OF INSURED: _____

SOCIAL SECURITY NUMBER OF INSURED _____

IF WORKMEN'S COMPENSATION CLAIM DATE OF ACCIDENT _____

Primary Insurance _____

Secondary Insurance _____

I.D. # _____ Group # _____

MEDICATIONS Please list: _____

ALLERGIES TO MEDICATIONS: _____

Family Physician: _____ Referring Physician: _____

How did you find out about Dr. Ridings? _____

ASSIGNMENT OF BENEFITS

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Edward H. Ridings, D.O., and any assisting physician, 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 healthcare provider 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.

Date: _____ Signature: _____