

**SCHEURER PHYSICIAN CLINICS
PATIENT REGISTRATION FORM**

Patient Information

Patient First Name _____ Initial _____ Last Name _____
Address _____ City _____ State _____ Zip _____
Social Security Number _____ Date of Birth _____
Home Phone Number _____ Work Phone Number _____
Employer Name & Address _____
Emergency contact person name and phone number: _____

If the patient is a child, please provide both parents name and address if not the same as the child's.

Father's name _____ Father's phone _____
Father's address _____ Social Security Number _____
Mother's name _____ Mother's phone _____
Mother's address _____ Social Security Number _____

We cannot provide treatment to a child without the permission of the parent or guardian.

Can we leave messages on your answering machine or with family members concerning appointments and or billing issues? (Circle one) YES NO

Who Referred Patient To This Office ? _____

Insurance Information

(Primary) Insurance _____
Name of Policy Holder _____ Birthdate of Policy Holder _____
Address (if different from above) _____
Patient's relationship to Policy holder (circle one) 1=self 2=spouse 3=child 4=other

(Secondary) Insurance _____
Name of Policy Holder _____ Birthdate of Policy Holder _____
Address (if different from above) _____
Patient's relationship to Policy holder (circle one) 1=self 2=spouse 3=child 4=other

Please Read Completely and Sign

Assignment of Insurance Benefits: I authorize payment directly to Scheurer Physician Clinics for surgical and/or medical services otherwise payable to me. I further authorize the release to my insurance company of any information necessary for completion of any claim. I understand that I will be held responsible for any charges not payable by this assignment.

If we do not participate with your insurance company or if you do not have office visit or well health visit coverage, payment is due in full on the date the service is received. Your visit will be coded as indicated by the Doctor or Physician Assistant who provided your care. Due to changes in Federal laws regulating your insurance company, it would be considered fraudulent to change that code once it has been submitted to them. It would also be against our office policy to change codes already reported to an insurance company. We hope this information will help you understand our coding of your visit with our office.

Signature of Patient/Guardian Date

Signature of Employee/Witness Date