REGISTRATION FORM

CHILD'S NAME:_____
(last) (first)

HOME ADDRESS:_____
(number) (street) (city) (state) (zip)

HOME PHONE:_____BIRTHDATE:_____AGE:____SSN:_____

CELL PHONE:_____

PARENTS' NAMES:_____MARITAL STATUS OF PARENTS:_____

FATHER EMPLOYED BY:_____

OFFICE ADDRESS:_____

OFFICE PHONE:_____OCCUPATION:_____

MOTHER EMPLOYED BY:_____

OFFICE ADDRESS:_____

OFFICE PHONE:_____OCCUPATION:_____

REFERRED BY:_____PHONE:_____

ADDRESS:_____

PHYSICIAN:_____PHONE:_____

ADDRESS:_____

BRIEFLY STATE REASON FOR VISIT:_____

_____

· **INSURANCE INFORMATION** ·

INSURANCE COMPANY_____ID#_____GP#_____

INSURANCE ADDRESS_____DEDUCTIBLE MET?_____

SUBSCRIBER'S NAME_____SUBSCRIBER'S BIRTHDATE_____

MEDICAID# AND STATE_____ELIGIBILITY DATES_____

This office participates with most insurances and will file claims if your deductible is met. If you are covered by Medicare and another insurance, please provide us with your other insurance information.

· RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS ·

I authorize release of medical information to my physician and/or other referring person.
I also authorize release of medical information necessary to process insurance claims
and assign claim benefits directly to MARIANNE SCHUELEIN, M.D.

_____

Authorized Signature / Date

PERSON RESPONSIBLE FOR BILL:_____