

G.P. Birkmann, OD

PATIENT REGISTRATION

Date: \_\_\_\_\_

File # \_\_\_\_\_

Patient Information

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_ S.S.# \_\_\_\_\_
Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_
Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status \_\_\_\_\_
Employer \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_
Work Status: \_\_\_ FT \_\_\_ PT \_\_\_ Retired \_\_\_ Student School \_\_\_\_\_ \_\_\_ FT \_\_\_ PT

Guarantor Information (Responsible Party)

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_ S.S.# \_\_\_\_\_
Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_
Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status \_\_\_\_\_
Employer \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_
Work Status: \_\_\_ FT \_\_\_ PT \_\_\_ Retired \_\_\_ Student School \_\_\_\_\_ \_\_\_ FT \_\_\_ PT

Patient & Insurance Information (we will need a copy of your insurance card)

Primary Insurance \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_
Phone \_\_\_\_\_ Type: Individual \_\_\_ Group \_\_\_ Medicaid \_\_\_ Medicare \_\_\_ Other \_\_\_
Group Name \_\_\_\_\_ Group/Plan # \_\_\_\_\_ ID# \_\_\_\_\_
Policy Holder \_\_\_\_\_ Birthdate \_\_\_\_\_ Relation: Self \_\_\_ Spouse \_\_\_ Parent \_\_\_
Other Insurance \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_
Phone \_\_\_\_\_ Type: Individual \_\_\_ Group \_\_\_ Medicaid \_\_\_ Medicare \_\_\_ Other \_\_\_
Group Name \_\_\_\_\_ Group/Plan # \_\_\_\_\_ ID# \_\_\_\_\_
Policy Holder \_\_\_\_\_ Birthdate \_\_\_\_\_ Relation: Self \_\_\_ Spouse \_\_\_ Parent \_\_\_

Assignment of Benefits, Release of Information, Payment Agreement, HIPAA Guidelines

I understand that payment is due at the time of service unless other arrangements have been made. I understand that G.P. Birkmann, OD will be filing my insurance on my behalf. I agree to have the benefits from my insurance assigned to G.P. Birkmann, OD. I permit G.P. Birkmann, OD to release any information deemed necessary to any insurance or third party, within the guidelines of HIPAA (Health Insurance Portability & Accountability Act of 1996). I agree that I am responsible for full payment of this account and any court costs and attorney fees associated with the collection of this account.

\_\_\_\_\_  
Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date