Douglas S. Pool, M.D.

A Medical Corporation

PATIENT REGISTRATION

Patient Information

Full Name:_____ Social Security #:_____

Phone (C):_____(H):_____ Date of Birth:_____

Address: _____

City: _____ State:_____ Zip:_____

E-Mail Address:_____

Sex: M or F Marital Status: S / M / D / W Employment: F / PT / NW Student: F / PT

Emergency Contact:_____ Relationship to Patient:_____

Phone:_____ Address:_____

Employer:_____ Employer Address:_____

Account/Guarantor Information (if different from above)

Name:_____ Social Security #:_____

Relationship to Patient:_____ Date of Birth:_____

Address:_____

City: _____ State:_____ Zip:_____

Phone (C):_____ (H): _____ Driver's License #:_____

Employer/Occupation:_____ E-Mail Address:_____

AUTHORIZATON FOR RELEASE OF MEDICAL INFORMATION: I authorize any holder of medical information about me to release said information requested by insurance companies with whom I have coverage or any public agency and its agents to determine benefits for services provided or benefits for related services.

ASSIGNMENT OF BENEFITS: I hereby authorize payment of benefits be made directly to the Practitioner for services provided to me by the Practitioner. I understand that I am financially responsible to the Practitioner for charges not covered by this assignment. In the event of default, I agree to pay all costs of collection including reasonable attorney's fees.

I Agree That I Am Ultimately Responsible For All Charges Incurred By The Above Patient.

_____ _____

Signature of Patient (If minor, signature of responsible person) **Date**

Revised 7/10/17