Laura Fiorenza, O. D.

Kim Bowling, L. D. O.

REGISTRATION
(Please Print)

Date ________________________ Home Phone (______)____________________ Cell Phone (______)______________________

PATIENT INFORMATION

Name ____ SS/HIC/Patient ID # ________________________________
Last Name First Name Middle Initial
Address ____ e-mail ____
City ____ State ___________ Zip ________________________
Sex ☐M ☐F Age _____________ Birthdate ____________ ☐Married ☐Widowed ☐Single ☐Minor ☐Separated ☐Divorced ☐Partnered for_______years
Patient Employer/School ___________________________________ Occupation _____________________________________
Employer/School Address ___________________________________ Employer/School Phone (______)___________________
Whom may we thank for referring you? ____
In case of emergency who should be notified? ____________________ Phone (______)_________________________________

PRIMARY INSURANCE

Person Responsible for Account ____
Last Name First Name Middle Initial
Relation to Patient ______________________________ Birthdate __________________ Soc. Sec # __________________
Address (if different from patient's) ____ Phone (______)________________
City ____ State ___________ Zip ________________________
Person Responsible Employed by ____ Occupation _________________
Business Address ____ Bus. Phone ________________
Insurance Company ____
Contact # ______________________________ Group # __________________ Subscriber # _________________
Names of other dependents covered under this plan ____

ADDITIONAL INSURANCE

Is patient covered by additional Insurance? ☐Yes ☐No
Subscriber Name ______________________________ Birthdate __________________ Soc. Sec # __________________
Address (if different from patient's) ____ Phone (______)________________
City ____ State _________ Zip ________________________
Subscriber Employed by ____ Relation to Patient _____________
Business Address ____ Bus. Phone _________________
Insurance Company ____
Contact # ______________________________ Group # __________________ Subscriber # ________________
Names of other dependents covered under this plan ____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with __________________________ and assign directly to
Name of Insurance Company(ies)
Dr. ___________________ all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ ____________________
Signature of Patient, Parent, Guardian or Personal Representative Date

____ ____________________
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient