JOSEPH B. JACOBS, M.D.

Patient Registration

Welcome to our office. Please fill out this form completely. In addition, please provide us with **ALL** medical insurance cards.

(Please Print)

All information will be strictly confidential.

Patient's Name: _____ Sex: M( ) F( ) Marital Status: Married ( ) Single ( ) Divorced ( ) Widowed( )	Contact information Home:_____Work:_____ Cell:_____ Fax: _____ E-Mail Address:_____ (**very important for follow-up**)

Mailing Address City State Zip			Date of Birth	Patient's Social Security #
Person financially responsible for this account	Self Spouse Parent	Responsible Party's Birthdate		Responsible Party's Social Security #
Name of employer Address			Business Phone	Occupation
Name of Spouse/Parent	Birth date	Social security #		Business phone
Reason for Visit:	Referred by: (include address and phone)			
Person to contact in case of emergency:	Relationship to patient		Phone	

PRIMARY INSURANCE COMPANY NAME:	Subscribers Name	Subscribers DOB	Policy ID #	Group #
SECONDARY INS. COMPANY NAME:	Subscribers Name	Subscribers DOB	Policy ID#	Group #

PLEASE PROVIDE US WITH ALL YOUR INSURANCE CARDS

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Joseph B. Jacobs, M.D. for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services

_____ _____

Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Joseph B. Jacobs, M.D. for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years old) Date

All accurate, up to date insurance information has been provided. I understand that I may be responsible for any out of network deductibles or coinsurance that are applied to the services rendered.

_____ _____

Patient, Parent or Guaridan Signature Date