

Michael J. Barnthouse, M.D.
PATIENT REGISTRATION INFORMATION

Please print, complete all information, and provide us with a copy of your health insurance coverage card.

PATIENT INFORMATION

Name _____ Date _____
(Last) (First) (Middle Initial) (Maiden Name)

Address _____ Date of Birth _____

City _____ State _____ Zip Code _____ Social Security No. _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email Address _____

Employment Status (circle) Full Time Part Time Not Employed Self Employed Retired
Active Duty Full Time Student Part Time Student

Name & Address of Employer _____

Marital Status (circle) Single Married Legally Separated Divorced Widowed Other _____

Primary Care Physician (PCP) _____ PCP's Phone No. _____
(Last) (First)

Referring Physician _____ Referring Physician's Phone No. _____
(Last) (First)

Responsible Party (if patient is under 18 yrs of age) _____

Relationship to Patient: _____

In case of Emergency, whom should we notify? _____ Phone No. _____

Relationship to Emergency Contact _____

Do you (patient) have a living will (advance directive) YES NO

How did you hear of our office? _____

INSURANCE INFORMATION

Primary Insurance Policy _____ I have no insurance

Subscriber's Name _____ Subscriber's Social Security No. _____
(Last) (First) (Middle Initial)

Relationship to Subscriber: Self Spouse Parent Other: _____ Subscriber's DOB _____

Subscriber's Employer _____ Employer Phone No. _____

Employer Address _____
Address City State Zip

Effective Date of Policy ____/____/____ Policy or Identification No. _____

Group No. _____

Claims mailing address _____
Address City State Zip

Secondary Insurance Policy (If applicable) I have no other insurance

Subscriber's Name _____ Subscriber's Social Security No. _____
(Last) (First) (Middle Initial)

Relationship to Subscriber: Self Spouse Parent Other: _____ Subscriber's DOB _____

Subscriber's Employer _____ Employer Phone No. _____

Employer Address _____
Address City State Zip

Effective Date of Policy ____/____/____ Policy or Identification No. _____

Group No. _____

Claims mailing address _____
Address City State Zip

ASSIGNMENT OF INSURANCE BENEFITS/AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Michael J. Barnthouse, M.D., P.C. to file insurance and assign benefits directly payable to Michael J. Barnthouse, M.D., P.C. I authorize Michael J. Barnthouse, M.C., P.C. to release any medical or incidental information that may be necessary for either medical care or processing for financial benefits. I understand insurance claims are filed as a courtesy. All balances (including balances for failure to obtain a referral) are my responsibility. Co-pays and co-insurances are due at the time of service. Failure to fulfill my financial obligation may result in my account being forwarded to an outside collection agency, which may result in additional fees and service charges. Delinquent accounts may be reported to the credit bureau. I also understand a fee will be charged for insufficient checks.

Patient Signature: _____ **Date:** _____

Responsible Party: _____ **Date:** _____