

**Michael J. Barnthouse, M.D.**  
**CHANGES TO PATIENT REGISTRATION INFORMATION**

Please ONLY complete the section that needs to be updated (Patient Info and/or Insurance Info)

**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 \_\_\_\_\_

Driver's License No. \_\_\_\_\_

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:** \_\_\_\_\_