PATIENT REGISTRATION

Last Name_____ Middle Initial____ First Name_____

Gender: Male / Female (circle one) SSN _____-____-_____ Birth Date ___/___/____

Street Address_____ City _____ State ____ Zip _____

Home Phone ____-_____-_____ Work Phone ____-____-_____ Cell ____-____-_____

E Mail_____ Marital Status_____

Primary Language _____ Race _____ Ethnicity Hispanic / Latino Not Hispanic / Latino

Student Status_____ Employment Status_____ Employer_____

Emergency contact name_____ Relationship_____ Phone#_____

Primary Insurance _____ Group#_____ ID_____ Subscriber Name_____

Secondary Insurance_____ Group # _____ ID_____ Subscriber Name_____

Whom may we thank for referring you? _____

Legal Representative _____DOB_____ Address_____

Relationship to the Patient_____

Who may we leave a message with: patient only, patient and/or spouse, anyone answering the phone
(Circle one)

I authorize the release of my medical information to medical professionals and insurance companies.

Informed Consent

I understand that I am financially responsible for all charges whether or not paid by insurance company (ies) and their agents for the benefits payable for related services provided by Dr. Hovancsek and or his staff.

_____ _____

Signature of Patient, Parent Guardian, or Representative Date