DANIEL R. HOWARD,MD, PA

PATIENT REGISTRATION FORM

Section I: Patient Information Date_____

Name:_____ Email address _____
Address:_____City:_____State:_____Zip_____
Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____
The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone
Date of Birth:_____ Social Security Number:_____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School_____ City/State_____ ☐ FT ☐ PT
Spouse or Parent's Name:_____ Employer_____
Work Phone_____Whom may we thank for referring you? _____
Person to contact in case of emergency_____ Phone_____
Email Address_____ Would you like to receive our e-newsletter? ☐ Yes ☐ No

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:_____ Relationship to Patient: _____
Address:_____
City:_____ State:_____ Zip:_____ Phone: (____)_____
Employer_____ Work Phone (____)_____ SSN#_____

Section III Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____
DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, PLEASE ADVISE STAFF OF THIS INFORMATION

AUTHORIZATIONS

I authorize permission for treatment of my medical conditions, and collection of any information necessary for medical treatment.

I authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree that y signature on this document authorizes my doctor's office to submit claims for benefits, for services rendered, without obtaining my signature on each claim to be submitted. I understand that I am financially responsible for any charges incurred, including any charges not covered by my insurance company.

Signature: _____. Date: _____

For Medicare Patients: I request that payment of authorized Medicare benefits for services rendered by Daniel R. Howard, MD, PA, be made directly to Daniel R. Howard, MD, PA.

I verify that I am not in a Medicare HMO.

Signature: _____. Date: _____