# PATIENT REGISTRATION

DATE:_____

Patient name_____Phone_____Married?_____
Male___Female___ Birthdate___/___/___ Age_____ SS#_____

Address_____City_____State_____Zip_____
Employer_____Phone_____

Spouse or Parent Name_____Phone_____
Male___Female___ Birthdate___/___/___ Age_____ SS#_____

Address_____City_____State_____Zip_____
Employer_____Phone_____

**Responsible party if different from above:(workman's comp or parent of dep not living with)**

Name_____Relationship_____Phone_____
Address_____City_____State_____Zip_____
Birthdate___/___/___Employer_____Phone_____
SS#_____

## Insurance Information

Primary_____
Company Address City State Zip
ID#_____Group#_____Insured Person_____

Secondary_____
Company Address City State Zip
ID#_____Group#_____Insured Person_____

In case of emergency notify:_____Phone_____Relationship_____

## Assignment & Release

I, the undersigned, have insurance coverage and assign directly to Dr. Custodio L. Lim all medical benefits, if any, otherwise payable to me for services rendered. If I do not have insurance, I understand that I am financially responsible for all charges. I also understand that I am financially responsible for co-insurance and deductible amounts. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____
Signature of insured/Guardian Date

## Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Custodio L. Lim for any services furneshed me by that physician. I authorize any holder of medical information about me to be released to the Health Care Financing Admin. and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician agrees to accept the charge determined by the Medicare carrier as the full charge and the patient is responsible only for the deductible and coinsurance.

_____
Signature of Medicare Recipient Date