Patient Registration Form

David Fredenburg, MD, PA

Patient Name: _____ Birth date: _____

Primary Insurance
(Please provide a copy of the current insurance card) Effective date: _____

Insurance company: _____ Phone #: (____)_____

Claims address: _____
Street / Road City / Town Zip code

Name of subscriber: _____ Social Security #: _____

Subscriber birth date: _____ Certificate / ID #: _____ Group #: _____

Employer: _____

Other Insurance
(Please provide a copy of the current insurance card) Effective date: _____

Insurance company: _____ Phone #: (____)_____

Claims address: _____
Street / Road City / Town Zip code

Name of subscriber: _____ Social Security #: _____

Subscriber birth date: _____ Certificate / ID #: _____ Group #: _____

Employer: _____

Emergency Notification (please provide name & phone number for someone not living in the same house)

Name: _____ Phone: _____

How did you hear about this practice? _____

I have provided information about all current insurance coverage for this patient and will notify the office when any changes in coverage occur. I authorize David Fredenburg MD PA to submit to my insurance carrier claims for care provided and to release any medical information necessary to process the claim. I authorize payment of medical benefits to David Fredenburg MD PA for and services for which assignment is accepted. I understand that I may be responsible for payment of all office services at the time of the visit. I have also had an opportunity to review the Office Policies posted in the office or provided with this registration, and am aware of its contents.

Patient/Parent/Guardian name (please print): _____

Signature: _____ Date: _____