JEFFREY R. ZOHNER, M.D., LLC.

PATIENT REGISTRATION FORM

PATIENT

This section refers to the PATIENT ONLY (make corrections as necessary)

Name: **Sex:** **Date of Birth:**

Address:

City, State, Zip:

Home Phone: **Cell Phone:**

SSN#:

Allergies: {Allergies}

Referred By: **Phone:**

Employer: **Work Phone:**

Address: **City, State, Zip:**

RESPONSIBLE PARTY

Review/ complete if person responsible for the bills is NOT the PATIENT!

Name: **Sex:** **Date of Birth:**

Address:

City, State, Zip: **SS#:**

Home Phone: **Work Phone:** **Employer:**

Spouse or Parent (if minor):

INSURANCE

Please list required information pertaining to your insurance coverage. If you have multiple coverage, supply information for both carriers.

Pri Carrier: **Sec Carrier:**

Insured: **Insured:**

Patient Relationship: **Patient Relationship:**

Insured ID #: **Insured ID #:**

Group #: **Group #:**

Insurance Address: **Insurance Address:**

Copay: **Copay:**

AUTHORIZATION

I hereby give ***JEFFREY R. ZOHNER, M.D., LLC.*** my consent for any necessary medical evaluation and treatment. I hereby authorize release of information necessary for my insurance company to process my claim and authorize payment directly to ***JEFFREY R. ZOHNER, M.D., LLC.***, benefits otherwise payable to me. I understand I am financially responsible for charges not paid in a timely manner by my insurance. The above information is correct to the best of my knowledge.

Signed: ______________________ Date: ______________