PRINT CLEARLY - PRESS HARD

David R. Benson, M.D.,O.D., PLLC

By what name would you like our office to address you ? _____

Patient Registration

PATIENT NAME

LAST FIRST MI BIRTHDATE AGE

SS#_____--_____--_____ *circle* MALE / FEMALE *circle* MARRIED / SINGLE / WIDOWED / DIVORCED / SEPARATED

HOME ADDRESS

STREET *APT #* CITY STATE ZIP

BILLING ADDRESS

IF DIFFERENT FROM ABOVE STREET *APT #* CITY STATE ZIP

PHONE #'S ( ) ( )

HOME WORK EMPLOYER

( )

PERSON TO CALL IN CASE OF EMERGENCY ***NOT LIVING WITH PATIENT*** PHONE RELATIONSHIP

PCP/ Regular Dr. _____ Referring Dr. _____ Other source _____

phone # *phone #* phone bk / Ins list / friend

CHILD LIVES WITH _____

Spouse or Parent Name Birthdate _____--_____--_____. SS# (Social Security Number)

( )

EMPLOYER WORK PHONE

Primary Insurance Coverage

RELATIONSHIP TO PATIENT *circle* **SELF / SPOUSE / PARENT** ☐ ***No Insurance Coverage***

NAME OF INSURANCE ID#

SUBSCRIBER'S NAME GROUP # CO-PAY

SUBSCRIBER'S DOB- **SS#** _____--_____--_____. **M / F**

WK # ( )

SUBSCRIBER'S ***EMPLOYER***

Secondary Insurance Coverage

RELATIONSHIP TO PATIENT *circle* **SELF / SPOUSE / PARENT** ☐ ***NO SECONDARY COVERAGE***

NAME OF INSURANCE ID#

SUBSCRIBER'S NAME GROUP #

SUBSCRIBER'S DOB SS # _____--_____--_____. **M / F**

INFORMATION / PAYMENT AUTHORIZATION

Services are rendered to the patient, not an insurance company. The sole responsibility for payment of services is the patient and/or guardian. I hereby assign to David R.Benson, M.D.,O.D., PLLC all money from the insurance company to which I am entitled for expenses relative to services rendered by him. In the event I fail to acquire an authorization required by my insurance from the PCP of record, I am responsible for charges incurred. A late fee of 1 % or $1.00 minimum, will be applied to accounts over due by 60 days or more which are patient responsibility. I authorize Dr. Benson to release any medical information to my insurance Co. necessary to process any claims made on my behalf.

By signing this form you are stating that all the information is true and correct to your knowledge, and that any notification delivered by the USPostal Service regular delivery is deemed valid notification to all parties listed above.

SIGNATURE *RELATIONSHIP TO PATIENT* *DATE*

A PHOTO COPY OF THIS FORM SHALL BE DEEMED AS VAILD AND AS EFFECTIVE AS THE ORIGINAL