Patient Registration Information

GENERAL INFORMATION					
Last Name	First Name			Middle Initial	
Home Address	City			State	Zip Code
Drivers License #	Social Security #	Age	Birth Date	Sex	Marital Status
				M / F	S M W D
Cell Phone #	Home Phone #	Email Address			
Spouse's Name		Spouse's Phone #			

RESPONSIBLE PARTY (if different than above)		
Name and Relationship	Address, City, State, Zip	Phone #

EMERGENCY CONTACT - Who should we contact in case of an Emergency - **OTHER** than your home?		
Name and Relationship	Address, City, State, Zip	Phone #

EMPLOYMENT INFORMATION			
PATIENT'S Employer		Phone	
Employer Address, City, State, Zip		Occupation	
SPOUSE'S Employer		Phone	
Employer Address, City, State, Zip		Occupation	

INSURANCE INFORMATION	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company Name		
Subscriber Name		
Subscriber Date of Birth		
Subscriber Employer		

REFERRAL INFORMATION - Who referred you to our office?		
May we thank them?	Name and Address	Phone #
Yes ☐ No ☐		

Authorization to pay benefits to Physician and Release of Medical Information

I hereby authorize payment directly to Michael J. Schenden M.D., P.C., for any medical benefits otherwise payable to me for their services. I hereby authorize Michael J. Schenden M.D., P.C., to release any medical information necessary for payment of my insurance claim. I understand I am responsible for payment of any services not covered by my insurance and all copays and deductibles. I authorize you to give reasonable and proper medical care as determined by today's standards.

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Patient Signature Date