Patient Registration Form – Insurance

Please provide the front desk with your driver's license and insurance card.

GENERAL INFORMATION				
Last Name	First Name			M.I.
Home Address	City		State	Zip Code

Last 4 Digits of SS #	Age	Birth Date	Sex	Marital Status
			M / F	S M W D

Cell Phone #	Home Phone #	Email Address

Would you like to receive office specials to email listed above? Y / N

Spouse's Name	Spouse's Phone #

EMERGENCY CONTACT – Who should we contact in case of an emergency – **OTHER** than your home?		
Name	Relationship	Phone #

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

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

REFERRAL INFORMATION		
How did you hear about our office? **INTERNET / SOCIAL MEDIA PATIENT OTHER:** _____		
May we thank them?	Name and Address	Phone #
Y / N		

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.

_____ _____

Patient Signature Date

Michael J. Schenden, M.D., PC, 201 W. Big Beaver Rd, Suite 1130, Troy, MI 48084
www.drschenden.com (248) 524-0620