REGISTRATION INFORMATION

Date_____

Patient Name (Last, First, MI):_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Birthdate: ____/____/_____ Age: _____ Sex M F Social Security Number_____

Mother's name: _____

Mother's home phone: _____ Mother's cell phone: _____

Social Security Number (mother):_____ Birthdate (mother):____/____/_____

Fathers's name: _____

Father's home phone: _____ Father's cell phone: _____

Social Security Number (father):_____ Birthdate (father):____/____/_____

Primary insurance company_____ Secondary insurance company_____

How did you hear of our practice? _____

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I, _____, hereby authorize my insurance company to pay directly to Danuta Jackson-Curtis, MD PA all benefits payable for services provided. I understand that I am financially responsible for all charges incurred, and that I am responsible for making sure that my insurance coverage is current and valid. If the services are not covered for any reason, including lapse of coverage, unmet deductibles and co-payments, co-insurance for vaccines, out-of-network or any other reason, I will personally be responsible for payment. I am not relying on anything verbally stated by Better Health Medical Center, Inc. staff.
I agree that should the need arise to reschedule or cancel appointments I will give at least a 24 hour notice.

_____ _____

Parent/Legal Guardian Date