REGISTRATION INFORMATION

(PLEASE PRINT)

PATIENT: ____
LAST NAME FIRST NAME INITIAL

ADDRESS: ____CITY_________________ST__________ZIP____________

HOME PHONE: (___) ________________________________CELL PHONE: (___)________________________________

SEX: M______F_______ AGE _________ BIRTHDATE _______________ SINGLE_____MARRIED_______WIDOWED_______

SS#: ___________-_____________-____________ EMAIL____

PATIENT EMPLOYED BY: ____

BUSINESS ADDRESS: _____________________________________BUSINESS PHONE:(___)______________________

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NAME OF RESPONSIBLE PARTY: ____
LAST NAME FIRST NAME INITIAL

ADDRESS: ____CITY____________________ST________ZIP__________

HOME PHONE: (__)_______________________ SS# ___________- __________-__________BIRTHDATE:________

EMPLOYED BY: ____

BUSINESS ADDRESS: ____BUSINESS PHONE: (___)_________________

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DO YOU HAVE MEDICAL INSURANCE? YES _______ NO ______

NAME OF PRIMARY INSURANCE CARRIER:____

ADDRESS: ____PHONE (___)________________________________

CONTRACT# _____________________________GROUP# __________________SS# ______- _______- ________

INSURED'S NAME ________________________________RELATIONSHIP TO PT _______________DOB:__________

NAME OF SECONDARY INSURANCE CARRIER (IF ANY): ____

ADDRESS: ____PHONE:(___)________________________________

CONTRACT#__________________________GROUP#_____________SS# _______- ________- _______

INSURED'S NAME ________________________________RELATIONSHIP TO PT_______________DOB:___________

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I HEREBY AUTHORIZE PAYMENT DIRECTLY TO JOHN J. OBI, M.D. FOR THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME UNDER TERMS OF MY INSURANCE. I HEREBY AUTHORIZE JOHN J.OBI, M.D. TO RELEASE ANY INFORMATION AQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT RELATING TO ALL CLAIMS FOR BENEFITS SUBMITTED ON BEHALF OF MYSELF AND/OR COVERED DEPENDENTS.
I AUTHORIZE ANY PHYSICIAN, HOSPITAL, OR MEDICAL CARE FACILITY TO PROVIDE ALL INFORMATION OR ANY MEDCIAL HISTORY AND TREATMENT TO JOHN J. OBI, M.D.
I HEREBY AUTHORIZE PHOTOCOPIES OF THIS FORM TO BE AS VALID AS THE ORIGINAL.

SIGNATURE: ____DATE ______________________________
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