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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