WELCOME ***SHEILA A. BOND, MD.***

PLEASE TAKE A FEW MINUTES TO ANSWER THE QUESTIONS ON BOTH SIDES OF THIS FORM, SO WE CAN BETTER ASSIST YOU WITH YOUR HEALTH CARE NEEDS.

PATIENT REGISTRATION INFORMATION

Date_____ SS#_____ DOB_____ Age_____ Sex: ( )M ( )F

Name_____
Last Name First Name Middle Initial

Address_____
Street City State Zip Code

Home Phone_____ Fax Number_____ Cellular or Beeper #_____

Email Address_____ Marital Status: ( )Minor ( )Single ( )Married ( )Divorced ( )Widowed ( )Separated

Employer_____ Occupation_____

Business Address_____ Business Phone_____

Whom may we thank for this referral?_____

In case of emergency, whom should we contact?_____ Phone No._____

PRIMARY INSURANCE

Person Responsible for Account_____
Last Name First Name MI

Relationship to Patient_____ DOB_____ SS#_____

Address_____ Home Phone_____

City_____ State_____ Zip_____

Responsible Party Employed by_____ Occupation_____

Address_____ Business Phone_____

Insurance Company_____ Phone No._____

Address_____

Subscriber ID#_____ Group#_____

ADDITIONAL INSURANCE (IF APPLICABLE)

Insured Name_____
Last Name First Name Middle Initial

Relationship to Patient_____ DOB_____ SS#_____

Address _____ Home Phone_____

Insurance Company_____ Phone No._____

Address_____

Subscriber ID#_____ Group#_____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Sheila A. Bond, MD all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents.

I authorize the above noted physician and/or any provider or supplier in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I am also aware that Dr. Bond does not make court appearances, if my visit has to do with a lawsuit.

Signature of Responsible Party_____ **Date**_____