

PATIENT REGISTRATION/UPDATE INFORMATION

Private M.D., LLC

Dr. Helen T. Gelhot

Date: _____ Phone Number: (_____) _____

Patient: _____ Social Security Number: _____ - _____ - _____
(Last Name, First Name, MI)

Street Address: _____

City: _____ State: _____ Zip: _____

Age: _____ Birthdate: ____/____/____ Sex: M / F (Circle one) Married/Single/Divorced/Widowed

Employer Name: _____

Employer Address: _____ Phone: (_____) _____
(Street) (City/State/Zip)

Spouse (or Guardian) Name: _____

Employer Name: _____

Employer Address: _____ Phone: (_____) _____
(Street) (City/State/Zip)

INSURANCE INFORMATION

Medicare #: _____ Effective Date: _____

PRIMARY INSURANCE CO.: _____ SECONDARY INSURANCE CO.: _____

Plan Name: _____ Eff. Date: _____ Plan Name: _____ Eff. Date: _____

Certificate or ID#: _____ Certificate or ID#: _____

Plan or Group#: _____ Plan or Group : _____

Policy Holder: _____ Policy Holder: _____

DOB: ____/____/____ Social Security No. ____ - ____ - ____ DOB: ____/____/____ Social Security No. ____ - ____ - ____

(Circle one) HMO PPO

In Case of emergency, who should be notified? _____ Phone (_____) _____

Who may we thank for referring you? _____

Please Read and Sign Below

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including private insurance, Medicare and other health plans to: Private M.D., L.L.C., St. Louis, MO. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges incurred. I herby authorize said assignee to release all information necessary to secure the payment. In addition to the foregoing, I herby authorize the release of my medical information by or between any of my treating physicians and my insurer, HMO, health benefits payer or any other entity (including but not limited to third party administrators, management companies and provider networks) involved in the administration of my health benefits.

Signature: _____ Date: _____