

John B. Sturgeon, M.D.

Conservative solutions, compassionate care

Patient Registration Information

Please **PRINT** and complete **ALL SECTIONS BELOW!**

PATIENT'S PERSONAL INFORMATION

Name: _____ Date of Birth: ____/____/____
LAST NAME FIRST NAME MIDDLE INITIAL

Street Address: _____ apt# _____ Gender: Male Female
Circle One

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Work Phone: (____) _____ Mobile Phone: (____) _____

e-mail address: _____ Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed

Spouse's name: _____ Spouse's Date of Birth: ____/____/____

Patient / Responsibility Party Information

Responsible Party: _____ Date of Birth: ____/____/____

Relation to Patient: Self Spouse Parent/Guardian
Circle One Social Security #: ____ - ____ - ____

Responsible Party's home phone: (____) _____ work phone: (____) _____

Street Address: _____ apt#: _____

City: _____ State: _____ Zip Code: _____

YOUR EMPLOYER: _____ Phone Number: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Your occupation: _____

SPOUSE'S Employer: _____ Phone Number: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Patient's Insurance Information

Subscriber: _____ Date of Birth: ____/____/____ Relation to Patient: _____

PRIMARY insurance company name: _____ ID #: _____

Billing Address: _____ Group #: _____

SECONDARY insurance company name: _____ ID #: _____

Subscriber: _____ Date of Birth: ____/____/____ Group #: _____

Billing Address: _____ Relation to Patient: _____

Referral/Emergency Contact Information

Referred By: _____ Other Physicians who care for you: _____

Emergency Contact Name: _____

Home Phone: (____) _____ Work Phone: (____) _____ Relation to Patient: _____

Assignment of Benefits / Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to John B. Sturgeon, MD, and any assisting physicians, for services rendered. I have received and read the Financial Policy, and understand I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits; and agree a photocopy of this agreement shall be as valid as the original. No guarantees have been made to me regarding the outcome of this care.

Date: _____

Your Signature: _____