

Date: _____

John H. Serocki, MD
PATIENT REGISTRATION

For Internal Use Only
Patient Number _____

Social Security # _____ Home Address _____
 First Name _____ Middle _____
 Last Name _____ City _____
 Sex _____ Date of Birth _____ E-Mail _____
 Marital Status Married Single Home Phone () _____
 Divorced Widowed Work Phone () _____
 (Check One) Employed Retired Full time student Referring Physician _____
 Other _____ How did you hear about us? _____
 Employer _____

PLEASE PROVIDE INSURANCE CARD TO THE RECEPTIONIST

Commercial Medicaid Medicare Worker's Compensation Other _____
 Insurance Company _____
 Insured / Card Holder's Name _____ Relationship _____
 Policy # _____ Group# _____ Phone () _____

Commercial Medicaid Medicare Worker's Compensation Other _____
 Insurance Company _____
 Insured / Card Holder's Name _____ Relationship _____
 Policy # _____ Group# _____ Phone () _____

Company Name _____ Phone () _____
 Supervisor's Name _____ Supervisor's Phone () _____

Social Security # _____ Sex _____
 First Name _____ Middle _____
 Last Name _____
 Home Phone () _____ Work Phone () _____

Social Security # _____ Sex _____
 Relationship _____ Day Time Phone () _____
 First Name _____ Middle _____
 Last Name _____ Work Phone () _____
 Address _____
 City _____ State _____ Zip _____
 Employer _____
 Employer's Address _____
 City _____ State _____ Zip _____

 Signature (patient or Parent if Minor) Date

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/ or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

 Signature (patient or Parent if Minor) Date

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.