



**PATIENT REGISTRATION INFORMATION**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_  
 STREET: \_\_\_\_\_ APT #: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ SEX: ( M / F )  
 ARE YOU EMPLOYED/STUDENT ? \_\_\_NO \_\_\_YES- EMPLOYER / SCHOOL NAME: \_\_\_\_\_  
 HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
 CELL: \_\_\_\_\_ Which is the best number to reach you? \_\_\_HOME \_\_\_CELL \_\_\_WORK  
 DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_ EMAIL: \_\_\_\_\_  
 MARITAL STATUS: \_\_\_M \_\_\_S \_\_\_W \_\_\_Significant Other IN CASE OF EMERGENCY, PLEASE CONTACT:  
 NAME: \_\_\_\_\_ RELATIONSHIP : \_\_\_\_\_ PHONE: \_\_\_\_\_

**\*\*\* Were You Referred By a Doctor? \_\_\_No (See Below) \_\_\_Yes: If Yes, please give us information on the doctor:**

**REFERRING MD NAME:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**Referred By:** \_\_\_Website \_\_\_Family/Friend – Pls Name: \_\_\_\_\_ **OTHER:** \_\_\_\_\_

\_\_\_\_\_

**HEALTH INSURANCE INFORMATION**

**PRIMARY INSURANCE NAME / CLAIMS ADDRESS:** \_\_\_\_\_  
 \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**ID#:** \_\_\_\_\_ **GROUP #:** \_\_\_\_\_ **ARE YOU THE POLICYHOLDER?** \_\_\_ YES

**IF NO - please complete the information below on the policy holder.**

**INSURED'S NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**SOCIAL SECURITY #:** \_\_\_\_\_ **SEX: (M/F)** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_

**EMPLOYER NAME:** \_\_\_\_\_ **EMPLOYER PHONE:** \_\_\_\_\_

**SECONDARY INSURANCE-** **NAME:** \_\_\_\_\_  
**PHONE:** \_\_\_\_\_ **ID#:** \_\_\_\_\_ **GROUP #:** \_\_\_\_\_

**INSURED'S NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SEX: (M/F)** \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION:**

I hereby authorize Alex Keller MD FACS PC; its associate physicians and para-professionals, to bill the above referenced health insurance companies on my behalf for any/all services performed. I hereby assign all insurance payment benefits directly to this physician group should they accept assignment to my insurance carriers. I understand that any payments that I may receive directly, for services which were billed on my behalf by the physicians, must be turned over to the physician. I hereby authorize the release of any information necessary to secure payment of benefits. I have read and understood the office financial policy and have been offered a copy of this as well as the notice of privacy practices. I agree and authorize the taking of photos / video for medical evaluation and documentation, research or publications. My identity will be protected. This authorization will remain in force indefinitely or until I revoke it in writing.

\_\_\_\_\_  
 PATIENT / LEGAL GUARDIAN SIGNATURE

\_\_\_\_\_  
 DATE