Registration Information

Please Print

Date_____

Home Phone: (_____) _____

Cell Phone: (_____) _____

I do herby give permission to this office, its successors and assigns to call any cell phones owned or utilized by me. Yes No

Last Name: _____ First: _____ Middle: _____

Prefer to be called: _____ Responsible Party :(if a minor) _____

Street address: _____ E-mail: _____

City: _____ State: _____ Zip: _____

Sex: ◯ M ◯ F Age: _____ Birthdate: _____

Race or Ethnicity: ◯White ◯Hispanic or Latino ◯Asian ◯African American ◯American Indian ◯Other ◯ Decline

◯ Minor ◯Single ◯Married ◯Widowed ◯Separated ◯ Divorced ◯ Partnered for _____ years

Patient or responsible party employer: _____

Occupation: _____ Employer phone number: (_____) _____

Purpose of visit: _____

Who is responsible for this account? _____ Relationship: _____

Patient social security: _____

Do you have medical insurance? ◯ Yes ◯No Medicare◯ Medicaid ◯ ID # _____

Name of Primary Insurer: _____Contract # _____Group # _____

Primary Cardholder Name: _____DOB: _____ SSN#_____

Name of Secondary Insurer: _____ Contract # _____ Group # _____

Secondary Cardholder Name: _____ DOB: _____ SSN# _____

I prefer to: ◯ Pay my balance in full at time of service ◯Pay my balance in full upon receipt of first statement ◯ Make payment arrangements prior to services being rendered.

In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney fees and such costs as the court deems proper.

In case of emergency contact: _____ Phone (_____) _____

I certify that I, and/ or my dependent(s) have insurance coverage with _____(Company) and assign directly to Dr. Lawrence O'Holleran all my insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize my signature on all insurance submissions. The above named physician may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal representative Relationship to Patient