

COMPLETE PATIENT REGISTRATION RECORD

PLEASE PRINT

Insurance Information

Patient _____
First M. Last

My plan is a: PPO HMO POS (point of service) Other

Single Married Divorced Widowed

Patient's relationship to responsible party:
 self spouse child guardian other

Date of Birth _____ Age _____

SS# _____

Primary Insurance _____

Address _____

Name of Insured _____ Birthdate _____

City _____ ST _____ Zip _____

Secondary Insurance _____

Phone # _____
Home cell

Name of Insured _____ Birthdate _____

Work ext.

Member ID # _____ Birthdate _____

e-mail address _____ Driver's License # _____

Person Responsible for Payment _____
 Self Spouse Parent

Address _____
City _____ ST _____ Zip _____

Patient Occupation/Employer _____

Work Address _____

Who referred you to our office? _____

AUTHORIZATION - EMAIL CONSENT AND PRIVACY NOTIFICATION (HIPAA)

Credit Card # _____ Visa – Mastercard – Amex – Discover

Expiration Date _____

Name of Insured _____ Policy # _____

Spouse's Name _____ Spouse's work address _____

Spouse's Insurance _____ Policy # _____

I authorize treatment and assignment of medical benefits to Dr. Reynard. I authorize charges to my credit card for inadequate or uncovered insurance payment(s) for which I am responsible. I have had an opportunity to review Dr. Reynard's HIPAA policy and email consent, and I agree to receive e-mail communication. Accounts 30 days past due are subject to 12% interest per annum. Administration fee of \$45.00 may be applied for appointments changed within 24 hours.

SIGNED: _____ Date: _____