## PATIENT REGISTRATION FORM

PATIENT INFORMATION	INSURANCE
Name	PRIMARY
Address	Phone
	Policy #
City State Zip	Insured Party's Name
Home Phone	Relationship to Insured
Cell Phone	Insured Party's Birth Date
Work Phone	SECONDARY
Email	Phone
Best # to Contact: Home Cell Work	Policy #
Sex: M F Birth Date	Insured Party's Name
	Relationship to Insured
SS# Marital Status	Insured Party's Birth Date
Employer	TERTIARY
Spouse's Name	Was this injury work related? Y
If Minor – Guardian Name & Relationship	Was this injury automobile related? Y N
	Claim No Claim
Emergency Contact	Adjuster
Relationship	Company
Phone	Phone
Date of injury, illness, or condition:	FaxClaim #
• • • • • • • • • • • • • • • • • • • •	Claim #
Primary Care Physician:	Phone:
Release of information: I authorize any physician, hospital, pharmacy, insurance co., et	Phone:
Release of information: I authorize any physician, hospital, pharmacy, insurance co., et benefits payable for this claim to any organization responsible for payment of this claim I hereby give my consent for D&J Medical to use any photographs or videotape of me I and Assignment: I certify that the information given by me in applying for payment und payers, is correct. I authorize payment of medical benefits to D&J Medical for the serv Responsibility agreement: I acknowledge financial responsibility for this account. I ut coinsurance, or any other charges incurred which are not paid by my insurers or other the undersigned shall pay reasonable attorney fees and collection expenses. It is understand to permit payment of Medicare benefits to provider, physicians, and pat my behalf for any services furnished to me by D&J Medical including physician service. Center for Medicare & Medicaid Services and its agents any information needed to determine the design of the design o	imployer, or organization to release any information regarding the medical history, or no rot only physician or medical service organization who will render care to the patient. For educational and/or insurance claim processing purposes. Insurance Certification for educational and/or insurance claim processing purposes. Insurance Certification fer titles XVII and XIX of the Social Security act, by my insurers, and any third party ices rendered. I authorize the use of the below signature on all insurance submissions, anderstand that I am responsible for payment of any health insurance deductible(s), hird party payers. Should this account be referred to an attorney or agency for collection, stood that all judgments in a court of law may bear interest at the legal rate.  In the interior is a court of authorized Medicare benefits be made either to me or on est. I authorize any holder of medical or other information about me to release to the termine these benefits or benefits for related services.  Medigap Policy:  Authorization edical for any services furnished me by D&J Medical. I authorize any holder of medical as agents any information needed to determine benefits. The parties of parties.  The properties of the supplier standards contained in the Federal disconcern business professional and operational matters (e.g. honoring warranties and
Release of information: I authorize any physician, hospital, pharmacy, insurance co., end benefits payable for this claim to any organization responsible for payment of this claim. I hereby give my consent for D&J Medical to use any photographs or videotape of meand Assignment: I certify that the information given by me in applying for payment und payers, is correct. I authorize payment of medical benefits to D&J Medical for the serv Responsibility agreement: I acknowledge financial responsibility for this account. I uncoinsurance, or any other charges incurred which are not paid by my insurers or other the undersigned shall pay reasonable attorney fees and collection expenses. It is unders Statement to permit payment of Medicare benefits to provider, physicians, and pat my behalf for any services furnished to me by D&J Medical including physician service. Center for Medicare & Medicaid Services and its agents any information needed to det request that payment of authorized Medicare benefits be made on my behalf to D&J Minformation about me to release to the Center for Medicare& Medicaid Services and its Email Privacy Policy: We will not sell, share or lease your personal information to this Medicare DMEPOS Supplier Standards: The products and/or services provided to your regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standard hours of operation). The full text of these standards can be obtained at http://ecfr.gpoac	imployer, or organization to release any information regarding the medical history, or no rot only physician or medical service organization who will render care to the patient. For educational and/or insurance claim processing purposes. Insurance Certification for educational and/or insurance claim processing purposes. Insurance Certification fer titles XVII and XIX of the Social Security act, by my insurers, and any third party ices rendered. I authorize the use of the below signature on all insurance submissions, anderstand that I am responsible for payment of any health insurance deductible(s), hird party payers. Should this account be referred to an attorney or agency for collection, stood that all judgments in a court of law may bear interest at the legal rate.  In the interior is a court of authorized Medicare benefits be made either to me or on est. I authorize any holder of medical or other information about me to release to the termine these benefits or benefits for related services.  Medigap Policy:  Authorization edical for any services furnished me by D&J Medical. I authorize any holder of medical as agents any information needed to determine benefits. The parties of parties.  The properties of the supplier standards contained in the Federal disconcern business professional and operational matters (e.g. honoring warranties and
Release of information: I authorize any physician, hospital, pharmacy, insurance co., et benefits payable for this claim to any organization responsible for payment of this claim. I hereby give my consent for D&J Medical to use any photographs or videotape of metand Assignment: I certify that the information given by me in applying for payment und payers, is correct. I authorize payment of medical benefits to D&J Medical for the serves Responsibility agreement: I acknowledge financial responsibility for this account. I uncoinsurance, or any other charges incurred which are not paid by my insurers or other the undersigned shall pay reasonable attorney fees and collection expenses. It is underses Statement to permit payment of Medicare benefits to provider, physicians, and pat my behalf for any services furnished to me by D&J Medical including physician service. Center for Medicare & Medicaid Services and its agents any information needed to detrequest that payment of authorized Medicare benefits be made on my behalf to D&J Minformation about me to release to the Center for Medicare& Medicaid Services and its Email Privacy Policy: We will not sell, share or lease your personal information to this Medicare DMEPOS Supplier Standards: The products and/or services provided to your regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standard hours of operation). The full text of these standards can be obtained at http://ecfr.gpoacks.	mployer, or organization to release any information regarding the medical history, or nor to any physician or medical service organization who will render care to the patient. for educational and/or insurance claim processing purposes.   Insurance Certification ler titles XVII and XIX of the Social Security act, by my insurers, and any third party ices rendered. I authorize the use of the below signature on all insurance submissions. Inderstand that I am responsible for payment of any health insurance deductible(s), hird party payers. Should this account be referred to an attorney or agency for collection, stood that all judgments in a court of law may bear interest at the legal rate.  I request that payment of authorized Medicare benefits be made either to me or on ess. I authorize any holder of medical or other information about me to release to the termine these benefits or benefits for related services.   Medigap Policy: Authorization edical for any services furnished me by D&J Medical. I authorize any holder of medical is agents any information needed to determine benefits.   In authorize any holder of medical as agents any information needed to determine benefits.   In authorize any holder of medical as agents any information needed to determine benefits.   In authorize any holder of medical as agents any information needed to determine benefits.   In authorize any holder of medical as agents any information needed to determine benefits.   In authorize any holder of medical as agents any information needed to determine benefits.   In authorize any holder of medical as agents any information and operational matters (e.g. honoring warranties and scess.gov. Upon request we will furnish you a written copy of the standards.
Release of information: I authorize any physician, hospital, pharmacy, insurance co., end benefits payable for this claim to any organization responsible for payment of this claim I hereby give my consent for D&J Medical to use any photographs or videotape of me and Assignment: I certify that the information given by me in applying for payment und payers, is correct. I authorize payment of medical benefits to D&J Medical for the serv Responsibility agreement: I acknowledge financial responsibility for this account. I uncoinsurance, or any other charges incurred which are not paid by my insurers or other the undersigned shall pay reasonable attorney fees and collection expenses. It is unders Statement to permit payment of Medicare benefits to provider, physicians, and pat my behalf for any services furnished to me by D&J Medical including physician service. Center for Medicare & Medicaid Services and its agents any information needed to det request that payment of authorized Medicare benefits be made on my behalf to D&J Minformation about me to release to the Center for Medicare& Medicaid Services and its Email Privacy Policy: We will not sell, share or lease your personal information to this Medicare DMEPOS Supplier Standards: The products and/or services provided to your regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standard hours of operation). The full text of these standards can be obtained at http://ecfr.gpoac	imployer, or organization to release any information regarding the medical history, or in or to any physician or medical service organization who will render care to the patient. For educational and/or insurance claim processing purposes. Insurance Certification is retitles XVII and XIX of the Social Security act, by my insurers, and any third party ices rendered. I authorize the use of the below signature on all insurance submissions, anderstand that I am responsible for payment of any health insurance deductible(s), into party payers. Should this account be referred to an attorney or agency for collection, stood that all judgments in a court of law may bear interest at the legal rate.  I eints: I request that payment of authorized Medicare benefits be made either to me or on ess. I authorize any holder of medical or other information about me to release to the termine these benefits or benefits for related services.  Medigap Policy: Authorization edical for any services furnished me by D&J Medical. I authorize any holder of medical is a gents any information needed to determine benefits.  The property of the standards contained in the Federal disconcern business professional and operational matters (e.g. honoring warranties and excess.gov). Upon request we will furnish you a written copy of the standards.
Release of information: I authorize any physician, hospital, pharmacy, insurance co., et benefits payable for this claim to any organization responsible for payment of this claim. I hereby give my consent for D&J Medical to use any photographs or videotape of metand Assignment: I certify that the information given by me in applying for payment und payers, is correct. I authorize payment of medical benefits to D&J Medical for the serves Responsibility agreement: I acknowledge financial responsibility for this account. I uncoinsurance, or any other charges incurred which are not paid by my insurers or other the undersigned shall pay reasonable attorney fees and collection expenses. It is underses Statement to permit payment of Medicare benefits to provider, physicians, and pat my behalf for any services furnished to me by D&J Medical including physician service. Center for Medicare & Medicaid Services and its agents any information needed to detrequest that payment of authorized Medicare benefits be made on my behalf to D&J Minformation about me to release to the Center for Medicare& Medicaid Services and its Email Privacy Policy: We will not sell, share or lease your personal information to this Medicare DMEPOS Supplier Standards: The products and/or services provided to your regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standard hours of operation). The full text of these standards can be obtained at http://ecfr.gpoacks.	Imployer, or organization to release any information regarding the medical history, or no rot on any physician or medical service organization who will render care to the patient. For educational and/or insurance claim processing purposes. Insurance Certification ler titles XVII and XIX of the Social Security act, by my insurers, and any third party ices rendered. I authorize the use of the below signature on all insurance submissions, anderstand that I am responsible for payment of any health insurance deductible(s), hird party payers. Should this account be referred to an attorney or agency for collection, stood that all judgments in a court of law may bear interest at the legal rate.  ients: I request that payment of authorized Medicare benefits be made either to me or on es. I authorize any holder of medical or other information about me to release to the termine these benefits or benefits for related services. Medigap Policy: Authorization edical for any services furnished me by D&J Medical. I authorize any holder of medical and parties.  The parties of parties are subject to the supplier standards contained in the Federal disconcern business professional and operational matters (e.g. honoring warranties and excess.gov. Upon request we will furnish you a written copy of the standards.  Relationship to patient:  Reason if unable to sign:  MinorPhysical
Release of information: I authorize any physician, hospital, pharmacy, insurance co., et benefits payable for this claim to any organization responsible for payment of this claim I hereby give my consent for D&J Medical to use any photographs or videotape of me I and Assignment: I certify that the information given by me in applying for payment und payers, is correct. I authorize payment of medical benefits to D&J Medical for the serv Responsibility agreement: I acknowledge financial responsibility for this account. I uncoinsurance, or any other charges incurred which are not paid by my insurers or other the undersigned shall pay reasonable attorney fees and collection expenses. It is understant to permit payment of Medicare benefits to provider, physicians, and pat my behalf for any services furnished to me by D&J Medical including physician service. Center for Medicare & Medicaid Services and its agents any information needed to det request that payment of authorized Medicare benefits be made on my behalf to D&J M information about me to release to the Center for Medicare& Medicaid Services and its Email Privacy Policy: We will not sell, share or lease your personal information to this Medicare DMEPOS Supplier Standards: The products and/or services provided to your regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standard hours of operation). The full text of these standards can be obtained at http://ecfr.gpoack.	imployer, or organization to release any information regarding the medical history, or no rot on any physician or medical service organization who will render care to the patient. For educational and/or insurance claim processing purposes. Insurance Certification ler titles XVII and XIX of the Social Security act, by my insurers, and any third party ices rendered. I authorize the use of the below signature on all insurance submissions, anderstand that I am responsible for payment of any health insurance deductible(s), hird party payers. Should this account be referred to an attorney or agency for collection, stood that all judgments in a court of law may bear interest at the legal rate. It is request that payment of authorized Medicare benefits be made either to me or on ses. I authorize any holder of medical or other information about me to release to the termine these benefits or benefits for related services. Medigap Policy: Authorization edical for any services furnished me by D&J Medical. I authorize any holder of medical as agents any information needed to determine benefits. To by J Medical are subject to the supplier standards contained in the Federal disconcern business professional and operational matters (e.g. honoring warranties and cocess.gov. Upon request we will furnish you a written copy of the standards.  Relationship to patient:  Reason if unable to sign:
Release of information: I authorize any physician, hospital, pharmacy, insurance co., et benefits payable for this claim to any organization responsible for payment of this claim I hereby give my consent for D&J Medical to use any photographs or videotape of me than the analysing and the series of the series of many consistency. I certify that the information given by me in applying for payment und payers, is correct. I authorize payment of medical benefits to D&J Medical for the serv Responsibility agreement: I acknowledge financial responsibility for this account. I uncoinsurance, or any other charges incurred which are not paid by my insurers or other the undersigned shall pay reasonable attorney fees and collection expenses. It is undertook the undersigned shall pay reasonable attorney fees and collection expenses. It is many behalf for any services furnished to me by D&J Medical including physician service Center for Medicare & Medicaid Services and its agents any information needed to detrequest that payment of authorized Medicare benefits be made on my behalf to D&J M information about me to release to the Center for Medicare& Medicaid Services and its Email Privacy Policy: We will not sell, share or lease your personal information to this Medicare DMEPOS Supplier Standards: The products and/or services provided to your genulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards hours of operation). The full text of these standards can be obtained at http://ecfr.gpoace.  **National Company** I certify that I have recedescribes the types of uses and disclosures of my protected health information that mighealth care operations. The Notice of Privacy Practices also describes my rights and D& describes the types of uses and disclosures of my protected health information that mighealth care operations. The Notice of Privacy Practices also describes my rights and D& describes the types of uses and disclosures of my protected health information that mighealth care operations. The Noti	Imployer, or organization to release any information regarding the medical history, or in or to any physician or medical service organization who will render care to the patient. For educational and/or insurance claim processing purposes. Insurance Certification leverage in the social Security act, by my insurers, and any third party ices rendered. I authorize the use of the below signature on all insurance submissions, anderstand that I am responsible for payment of any health insurance deductible(s), hinted party payers. Should this account be referred to an attorney or agency for collection, stood that all judgments in a court of law may bear interest at the legal rate.  I request that payment of authorized Medicare benefits be made either to me or on es. I authorize any holder of medical or other information about me to release to the termine these benefits or benefits for related services. Medigap Policy: Authorization edical for any services furnished me by D&J Medical. I authorize any holder of medical agents any information needed to determine benefits.  In authorize any holder of medical or determine benefits.  Relationship to patient:  Reason if unable to sign:  MinorPhysical  Address of Authorized Representative  Relationship to patient:  Reason if unable to sign:  MinorPhysical  Address of Authorized Representative
Release of information: I authorize any physician, hospital, pharmacy, insurance co., et benefits payable for this claim to any organization responsible for payment of this claim I hereby give my consent for D&J Medical to use any photographs or videotape of me I and Assignment: I certify that the information given by me in applying for payment und payers, is correct. I authorize payment of medical benefits to D&J Medical for the serv Responsibility agreement: I acknowledge financial responsibility for this account. I ut coinsurance, or any other charges incurred which are not paid by my insurers or other the undersigned shall pay reasonable attorney fees and collection expenses. It is understant to permit payment of Medicare benefits to provider, physicians, and pat my behalf for any services furnished to me by D&J Medical including physician service. Center for Medicare & Medicaid Services and its agents any information needed to det request that payment of authorized Medicare benefits be made on my behalf to D&J M information about me to release to the Center for Medicare& Medicaid Services and its Email Privacy Policy: We will not sell, share or lease your personal information to this Medicare DMEPOS Supplier Standards: The products and/or services provided to your regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standard hours of operation). The full text of these standards can be obtained at http://ecfr.gpoace.  **Example Company of the Center of Privacy Practices** I certify that I have recedescribes the types of uses and disclosures of my protected health information that mighealth care operations. The Notice of Privacy Practices also describes my rights and DA Practices is posted in the patient waiting room. D&J Medical reserves the right to change health care operations.	Imployer, or organization to release any information regarding the medical history, or more to any physician or medical service organization who will render care to the patient. For educational and/or insurance claim processing purposes. Insurance Certification ler titles XVII and XIX of the Social Security act, by my insurers, and any third party ices rendered. I authorize the use of the below signature on all insurance submissions. Inderstand that I am responsible for payment of any health insurance deductible(s), hird party payers. Should this account be referred to an attorney or agency for collection, stood that all judgments in a court of law may bear interest at the legal rate.  I request that payment of authorized Medicare benefits be made either to me or on es. I authorize any holder of medical or other information about me to release to the termine these benefits or benefits for related services. Medigap Policy: Authorization edical for any services furnished me by D&J Medical. I authorize any holder of medical agents any information needed to determine benefits.  In authorize any holder of medical or other information about me to release to the termine these benefits or benefits for related services. Medigap Policy: Authorization edical for any services furnished me by D&J Medical. I authorize any holder of medical agents any information needed to determine benefits.  In authorize any holder of medical or other information and policy and the rederal decess.gov. Upon request we will furnish you a written copy of the standards.  Relationship to patient:  Reason if unable to sign:  MinorPhysical  Address of Authorized Representative  Reason if unable to sign:  MinorPhysical  Reason if unable to sign:  MinorPhysical  Reason if unable to sign:  MinorPhysical  Reduced duties with respect to my protected health information. The Notice of Privacy get the privacy practices that are described in the Notice of Privacy Practices. I may obtain yee the privacy practices that ar
Release of information: I authorize any physician, hospital, pharmacy, insurance co., et benefits payable for this claim to any organization responsible for payment of this claim I hereby give my consent for D&J Medical to use any photographs or videotape of me and Assignment: I certify that the information given by me in applying for payment und payers, is correct. I authorize payment of medical benefits to D&J Medical for the serv Responsibility agreement: I acknowledge financial responsibility for this account. I ur coinsurance, or any other charges incurred which are not paid by my insurers or other the undersigned shall pay reasonable attorney fees and collection expenses. It is unders Statement to permit payment of Medicare benefits to provider, physicians, and pat my behalf for any services furnished to me by D&J Medical including physician service Center for Medicare & Medicaid Services and its agents any information needed to det request that payment of authorized Medicare benefits be made on my behalf to D&J M information about me to release to the Center for Medicare& Medicaid Services and its made and the privacy Policy: We will not sell, share or lease your personal information to this Medicare DMEPOS Supplier Standards: The products and/or services provided to your regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standar hours of operation). The full text of these standards can be obtained at http://ecfr.gpoack.  X  Patient (Beneficiary) or Authorized Representative  Acknowledgement of Receipt of Notice of Privacy Practices I certify that I have recedescribes the types of uses and disclosures of my protected health information that mighealth care operations. The Notice of Privacy Practices also describes my rights and Departices is posted in the patient waiting room. D&J Medical reserves the right to chan, a revised Notice of Privacy Practices by calling the office and requesting a revised copy.  In accordance with HIPAA regulations, you may als	Imployer, or organization to release any information regarding the medical history, or more to any physician or medical service organization who will render care to the patient. For educational and/or insurance claim processing purposes. Insurance Certification lever titles XVII and XIX of the Social Security act, by my insurers, and any third party ices rendered. I authorize the use of the below signature on all insurance submissions. Inderstand that I am responsible for payment of any health insurance deductible(s), hird party payers. Should this account be referred to an attorney or agency for collection, stood that all judgments in a court of law may bear interest at the legal rate.  I request that payment of authorized Medicare benefits be made either to me or on es. I authorize any holder of medical or other information about me to release to the termine these benefits or benefits for related services. Medigap Policy: Authorization edical for any services furnished me by D&J Medical. I authorize any holder of medical agents any information needed to determine benefits.  In authorize any holder of medical agents any information needed to determine benefits.  In authorize any holder of medical agents any information needed to determine benefits.  In authorize any holder of medical agents any information needed to determine benefits.  In authorize any holder of medical agents any information needed to determine benefits.  In authorize any holder of medical agents and in the Federal desconcern business professional and operational matters (e.g. honoring warranties and access.gov. Upon request we will furnish you a written copy of the standards.  Relationship to patient:  Reason if unable to sign:  Minor Physical  Reason if unable to sign:  Minor Physical  Reason if unable to sign:  Minor Physical  Redaid active any protected health information. The Notice of Privacy get the privacy practices that are described in the Notice of Privacy Practices. I may obtain yee the privacy
Release of information: I authorize any physician, hospital, pharmacy, insurance co., et benefits payable for this claim to any organization responsible for payment of this claim. I hereby give my consent for D&J Medical to use any photographs or videotape of metand Assignment: I certify that the information given by me in applying for payment und payers, is correct. I authorize payment of medical benefits to D&J Medical for the serv Responsibility agreement: I acknowledge financial responsibility for this account. I uncoinsurance, or any other charges incurred which are not paid by my insurers or other the undersigned shall pay reasonable attorney fees and collection expenses. It is unders Statement to permit payment of Medicare benefits to provider, physicians, and patmy behalf for any services furnished to me by D&J Medical including physician service. Center for Medicare & Medicaid Services and its agents any information needed to detrequest that payment of authorized Medicare benefits be made on my behalf to D&J M information about me to release to the Center for Medicare& Medicaid Services and its minormation about me to release to the Center for Medicare& Medicaid Services and its Medicare DMEPOS Supplier Standards: The products and/or services provided to you regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standard hours of operation). The full text of these standards can be obtained at	