PATIENT REGISTRATION

PATIENT's First name_____Middle_____Last_____

S.S.N._____Birth Date_____

Phone Numbers: Home_____Cell_____Work_____Other_____

Mailing Address_____ Lot No / Appt. No._____

City _____ State_____ Zip Code_____ Parish_____

Physical Address (if different from mailing) _____Lot_____Appt_____
City_____State_____Zip Code_____Parish_____

In Case Of Emergency, Contact:_____Phone No._____Relationship_____

Driver's Lic. No._____ State_____Male__,Female__,Married__,Single__,Widowed__,Divorced__

Referring Physician:_____Primary Care Physician_____
RESPONSIBLE FOR BILL: Self_____ Another Patient_____ Responsible Party_____Other (explain)_____

EMPLOYER_____Phone No._____
Address_____City_____State_____Zip_____

INSURANCE COVERAGE - PRIMARY (present your insurance card to the receptionist at the time of your visit)
Name of Company_____
CARD HOLDER ID (if not printed on card)_____Effective_____
Name of Insured_____Relationship to Patient_____
Insured Address (If different from patient)_____
City_____ State_____ Zip Code_____
Date of Birth_____Employer_____

INSURANCE COVERAGE - SECONDARY (present your card to the receptionist at the time of your visit)
Name of Company_____
CARD HOLDER ID(if not printed on card)_____Effective_____
Name if Insured_____Relationship to Patient_____
Insured Address (If different from patient)_____
City_____State_____Zip Code_____
Date of Birth_____Employer_____

PLEASE LIST ADDITIONAL INSURANCE COVERAGE (S) ON THE BACK OF THIS FORM.

All professional services rendered are charged directly to the patient. The patient is responsible for all fees, regardless of insurance coverage or status of any insurance claim(s). It is customary to pay for service at the time it is rendered unless other arrangements have been made in advance.

I hereby give my consent and/or permission to any insurance carrier including Blue Cross and Blue Shied of Louisiana Medicare Services to release any information regarding the status of my claim(s) directly to Robert D. Marx, M.D..

I hereby authorize Robert D. Marx, M.D. to furnish information to my insurance carrier(s) concerning my medical history, illness(es) and treatments. I hereby authorize my insurance benefits including major medical, Medicare, private insurance and/or any other health plan benefits which I, my spouse, or my dependents are entitled to, to be paid directly to Robert D. Marx, M.D.. I hereby authorize Robert D. Marx, M.D. to release all information necessary to secure the payment(s) of these benefits. A photocopy of this assignment shall be considered as valid as the original. This assignment will remain in effect until revoked by me in writing. In the event my account is assigned to collection, I agree to pay all costs of collection, including reasonable attorney fees.

I HAVE READ AND UNDERSTAND THE ABOVE PARAGRAPHS

Signature_____Date_____