Dr. Edward Luan & Dr. Jill Birkholz

PATIENT REGISTRATION

DATE ____/____/_____

Social Security _____/___/_____ DOB ____/____/_____

Patient First Name _____ Int ___ Maiden Name_____ Last Name_____

Employer Name_____ Retired/Unemployed/Student Work#_____

Patient Address_____ Apt____ City_____ State____ Zip____

Phone Numbers Home#_____ Cell#_____

E-mail Address_____

Referring Physician_____ Marital Status Married/Single/Divorced/Widowed/Separated

PRIMARY INSURANCE NAME _____

Group#_____ Effective Date ___/___/___ Termination Date ___/___/___

ID#_____ Copay $_____ *Subscriber* Social Security _____/___/_____

Subscriber Name_____ Relationship _____ DOB ____/____/_____

Home#_____ Cell#_____ Employer Name_____

SECONDARY INSURANCE NAME _____

Group#_____ Effective Date ___/___/___ Termination Date ___/___/___

ID#_____ Copay $_____ *Subscriber* Social Security _____/___/_____

Subscriber Name_____ Relationship _____ DOB ____/____/_____

Home#_____ Cell#_____ Employer Name_____

RESPONBILE PARTY NAME _____ Self/Spouse/Parent/Other

Address_____ City_____ State____ Zip____

Phone Numbers Home#_____ Cell#_____

Initial Preferred Hospital & Gen Path METHODIST___ PROCTOR___ OSF___ GenPath___

Emergency Contact Spouse/Parent/Other Name_____

Phone Numbers Home#_____ Cell#_____

AUTHORIZATION: (1) to pay benefits to Physician: I hereby authorize payment to the physician of medical/surgical benefits, if any, otherwise payable to me for his/her as described, realizing I am responsible to pay non-covered services; and (2) for the physician to release information acquired in the course of my treatment to process claims.

Signature_____ Date_____

(Patient or Patent/Guardian if child is under the age of 18)

02252021