

Douglas L. Gaker, M.D., Inc.

REGISTRATION FORM

(Please Print)

Today's date:

PCP or Family Dr:

PATIENT INFORMATION

Patient's last name:

First:

Middle:

Marital status (circle one)

Mr. Mrs. Miss Ms.

Single / Mar / Div / Sep / Wid

Is this your legal name? If not, what is your legal name? (Former name):

Yes No

Birth date:

Age:

Sex:

/ /

M F

Street address:

Social Security no.:

Home phone no.:

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P.O. Box:

City:

State:

ZIP Code:

Occupation:

Employer:

Employee phone no.:

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REFERRED TO US BY DR.:

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:

Birth date:

Address (if different):

Home phone no.:

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Is this person a patient here? Yes No

Occupation:

Employer:

Employer address:

Employer phone no.:

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Is this patient covered by insurance? Yes No

Please indicate primary insurance

Subscriber's name:

Subscriber's S.S. no.:

Birth date:

Group no.:

Policy no.:

Co-Payment:

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Patient's relationship to subscriber: Self Spouse Child Other

Name of secondary insurance (if applicable):

Subscriber's name and Birth date:

Group no.:

Policy no.:

Patient's relationship to subscriber: Self Spouse Child Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): Relationship to patient: Home phone no.: Work phone no.:

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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize "DOUGLAS L. GAKER, MD, INC." or insurance company to release any information required to process my claims. I understand that I am responsible to update this information anytime it changes. I have read and understand the Office Policies (Scheduling & Appointments, Billing of Claims and HIPAA Privacy Policy – see back of this sheet).

Patient/Guardian signature

Date