

REGISTRATION FORM

**PATIENT INFORMATION**

Email \_\_\_\_\_  
 Name \_\_\_\_\_ Home phone (\_\_\_\_) \_\_\_\_\_ Cell phone \_\_\_\_\_  
 Street Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_  
 Male Female Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_  
 Employer/Dept. \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_  
 Referring Physician \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_  
 Family Physician \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Patient's Relationship to Responsible party : (circle) Child Stepchild Spouse Other: \_\_\_\_\_  
 Name (First, Middle, Last) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
 Home Address (circle if same) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_  
 Employer/Dept. \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
 Employer's street address \_\_\_\_\_ City/state/Zip \_\_\_\_\_  
 Spouse name (if applicable) \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_  
**\*\*Emergency contact name** (not at patient address) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**FOR PROPER FILING OF INSURANCE THE FOLLOWING MUST BE COMPLETED IN FULL**

**INSURANCE INFORMATION**

<b>Primary Carrier</b>	Insurance Company _____	Effective Date _____
Claim Address _____	City/State/Zip _____	
Policy holder _____	Date of birth _____	Relationship to patient : Spouse Parent Self Stepparent Guardian Social Security #: _____
Policy (ID) No. _____	Group No. _____	Employer _____ Phone (____) _____
<b>2nd Carrier</b>	Insurance Company _____	Effective Date _____
Claim Address _____	City/State/Zip _____	
Policy holder _____	Date of birth _____	Relationship to patient : Spouse Parent Stepparent Guardian Social Security #: _____
Policy (ID) No. _____	Group No. _____	Employer _____ Phone (____) _____

I understand that all charges are my responsibility to pay. If I carry insurance, I realize that insurance payments do not always cover specialty fees and that I am responsible for the part not covered. I hereby authorize payment directly to Jeffrey R. Leipzig, M.D.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_