REGISTRATION FORM

SURNAME (Last)____________________________FIRST NAME________________________

STREET ADDRESS____

CITY_________________________________ STATE ________________ZIP CODE____________

Employed? Yes no NAME OF EMPLOYER/SCHOOL________________________________

HOME PHONE: _____________________ WORK PHONE _____________________EXT____

DATE OF BIRTH: ___________________ SOCIAL SECURITY #_____-_____-_____

MARITAL STATUS: _________________ FAMILY PHYSICIAN____________________

PRIMARY INSURANCE COMPANY: ____

IDENTIFICATION NUMBER GROUP NUMBER

NAME OF INSURED PARTY EMPLOYER

RELATIONSHIP TO PATIENT DATE OF BIRTH

SECONDARY INSURANCE COMPANY:____

IDENTIFICATION NUMBER GROUP NUMBER

NAME OF INSURED PARTY EMPLOYER

RELATIONSHIP TO PATIENT DATE OF BIRTH

EMERGENCY CONTACT PHONE RELATIONSHIP
(Other than spouse)

ADDRESS

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Henry D. Train, M.D. for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Henry D. Train, M.D. to release any medical on incidental information that may be necessary for other medical care or in processing claims/applications for financial benefit.

Signature: ____________________________Date: ___________________________________

Finally, I agree that, if I do not pay my full account balance in 30 days and Dr Henry Train refers this account to a collection agency and/or attorneys for collection efforts, I will also be responsible for and agree to reimburse Dr. Henry Train for any and all reasonable collection fees (currently 30% of the balance due), legal fees, filing fees, service costs and disbursements incurred as a result of the collection effort.

Signature: ______________________________Date: ___________________________________