

PATIENT REGISTRATION

PLEASE ANSWER ALL QUESTIONS IN THIS SECTION

DATE: _____

Patient's Name: _____
Parent's Name (minors only): _____
Social Security Number: _____ - _____ - _____
Date of Birth: _____ Sex: (circle) M F
Marital Status: (circle) Single Married Divorced Widowed
Drug Allergies: _____
Medications Currently Taking: _____
Family Doctor: _____
Referring Physician: _____
Referring Physician Address: _____
Reason for Visit: _____

Home Phone: () _____
Cell Phone: () _____
Address: _____
City, State, Zip: _____
E-mail Address: _____
Employer: _____
Employer's Address: _____
Employer's Phone #: () _____

HEALTH INSURANCE INFORMATION

Insurance Company: _____ Identification Number: _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____
Do you have a referral from your primary care physician for today's visit? (circle) YES NO
Subscriber's Social Security #: _____ - _____ - _____

MEDICARE PATIENTS ONLY

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Christopher J. Saunders, M.D., P.A. / Dr. Benjamin Cooper, M.D. for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

Signature: _____ Date: _____

IF YOUR INJURIES OCCURRED AT WORK OR IN AN AUTO ACCIDENT YOU MUST COMPLETE THE FOLLOWING OR YOU WILL BE BILLED FOR THESE SERVICES

Insurance Company: _____ Identification Number: _____
Claims Mailing Address: _____ Claim Number: _____
City, State, Zip: _____ Claims Adjuster: _____
Phone Number: (____) _____

I request that payment of authorized Insurance Benefits be made either to me, or on my behalf to Dr. Christopher J. Saunders, M.D., P.A. / Dr. Benjamin Cooper, M.D.. I authorize any holder of medical information about me to release any said information needed to facilitate payment for related services."

Signature: _____ **Date:** _____

ATTENTION -- Where did you hear about us?

Circle one: Yellow Pages Physician Referral Friend Delaware Today Former Patient
Seminar, date: _____ Website: _____ Other: _____