PATIENT REGISTRATION

SAMUEL R. HEISER, M.D.
450 Lafayette Road
Noblesville, Indiana 46060
(317) 776-8748

Date: _____

Last Name _____ First Name _____ M.I. _____ S.S.# _____

Address _____ City/State/Zip _____ Birthdate _____ Sex _____

Telephone No.: Home _____ Work _____ Marital Status _____

Employer _____ Address _____ City/State/Zip _____

Referring Doctor: _____ Family Doctor: _____

Address _____ Address _____

Allergies _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Last Name _____ First Name _____ M.I. _____ Relation to Patient _____

Telephone No.: Home _____ Work _____ Address _____ City/State/Zip _____

PERSON RESPONSIBLE FOR BILL

Last Name _____ First Name _____ M.I. _____ Relation to Patient _____ S.S.# _____

Address _____ City/State/Zip _____ Birthdate _____

Telephone No.: Home _____ Work _____

INSURANCE INFORMATION (All questions relate to policy holder)

Name _____ Employer _____ Employer Address _____

Insurance Company Name _____ Insurance Company Address _____

Group # _____ Plan# _____

Patient's Relationship to Policyholder — Please check one: Self _____ Spouse _____ Child _____ Other _____

AUTHORIZATION

I hereby authorize the release of medical information for the purpose of validating and determining benefits from any insurance carrier.

Signature _____ Date _____

I hereby authorize the release of payment of all medical benefits for services rendered by Dr. Paul Waltt/Dr. Samuel R. Heiser to him directly. I realize I am responsible to pay non-covered services, and in consideration of the furnishing of medical and related services, hereby guarantee payment in full within 30 days or as otherwise arranged. I agree that in the event of default in payment, reasonable attorneys fees and cost of collections may be added to the amount due on the account.

Signature _____ Date _____

I request that payment of authorized Medicare benefits be made on my behalf for services furnished me by Dr. Paul Waltt/Dr. Samuel R. Heiser including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services.

Signature _____ Date _____