DSCS Patient Registration

Date: ____________________

Patient ________________________________ Age ___________ DOB _________________

Mailing Address: ___________________________ SSN: _____________________ M or F

____ Home Phone ______________________

Physical Address ____

Cell Phone ________________________ Email ____________________________________

Employer ____

Employer Address ____

Employer Phone _____________________________ Occupation ______________________

<u>SPOUSE</u> ______________________________ DOB ______________________________

Phone __________________________________ SSN ________________________________

Employer ____

Employer Address ____

GUARANTOR _____________________________ Relationship to Patient ______________

Emergency Contact _________________________ Phone _____________________________

PCP_________________________________Pharmacy_________________________________

RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE STATEMENT, AND AGREEMENT TO PAY FOR SERVICES

I hereby authorize **DSCS** to release any information necessary to process my insurance/Medicare claim, acquired in the course of my examination or treatment; to allow a photocopy of my signature to be used to process my insurance/Medicare claim for a period of **LIFETIME.** I claim any insurance benefits due me for services rendered by **DSCS** and authorize direct my carrier to issue payment directly to **DSCS**. Regardless of my insurance benefits, if any, I understand that I am fully financially responsible for any and all fees incurred, and I agree to pay such fees in full. The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose pre-certification/second opinion requirements for any and all plans to which I subscribe, may cause me to incur full liability for professional charges, as a result of non-payment by any carrier.

Patient Signature ______________________________________ Date ___________________