Scheidler Medical Preferred, LLC
Registration Form

PATIENT INFORMATION

Patient's Last Name: First: Middle: ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Street Address: Social Security No.: Home Phone No.:

P.O Box: City: State: Zip Code:

Occupation: Employer: Employer Phone No.:

How did you hear about us: ☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

INSURANCE INFORMATION
(Please give your insurance card to the receptionist.)

Person responsible for bill: Birth Date: Address (if different): Home Phone No.:

Is this person a patient here? ☐ Yes ☐ No

Occupation: Employer: Employer Address: Employer Phone No.:

Is this patient covered by insurance ☐ Yes ☐ No

Please indicate primary insurance:

Subscriber's Name: **Subscriber's S.S. No.:** **Birth Date:** **Group No.:** **Policy No.:** **Co-Payment:**

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary insurance (if applicable): Subscribers name: Group No.: Policy No.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative: Relationship to Patient: Home Phone No.: Work Phone No.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Dr. Stanley Scheidler or insurance company to release any information required to process my claims.

Patient/Guardian Signature *Date*