



**~ Registration Form ~**

**Patient Information:**

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last Name First Name Middle Initial

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone: ( \_\_\_\_\_ ) Cell Phone: ( \_\_\_\_\_ )

Email Address: \_\_\_\_\_

Sex:  Male  Female Age: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Status:  Single  Married  Separated  Widowed  Divorced  Minor  
 Other \_\_\_\_\_

Employer/School: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer/School Phone: ( \_\_\_\_\_ )

In Case Of Emergency who should be notified? \_\_\_\_\_

Emergency Contact Phone: ( \_\_\_\_\_ ) Relationship to patient: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**Primary Insurance:**

Is the patient listed above the primary insurance holder?  Yes  No

If No, Policy Holder Name: \_\_\_\_\_  
Last Name First Name Middle Initial

Policy Holder Date of Birth: \_\_\_\_\_ Relationship \_\_\_\_\_

**Assignment and Release:**

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Jeffrey J. Backenstoos, D.O., DBA Capstone Medical Associates, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient