Dr. Michael D. Sheps

PATIENT REGISTRATION ACCT #_____

Name: First_____Last_____Date_____

Date of Birth_____Age_____Sex_____Marital Status_____

Guardian (If pt. < 18): First_____Last_____

Patient (or Guardian): Driver License #_____Social Security #_____

Home Address_____

Home Phone_____Cell Phone_____

Work Phone_____Email_____

Occupation_____Employer_____

Pt. Spouse (or 2nd Guardian): First_____Last_____

Home Address_____

Home Phone_____Cell Phone_____

Work Phone_____Email_____

Occupation_____Employer_____

Emergency Contact_____Phone_____

Referred by_____Primary Physician_____

Health Insurance: Co._____Group #_____

Name of Insured_____Policy ID #_____

Check One: PPO_____HMO_____Medicare_____MediCal_____Work Comp_____Auto_____Lien_____

2nd Insurance: Co._____Group #_____

Name of Insured_____Policy ID #_____

Check One: PPO_____HMO_____Medicare_____MediCal_____Work Comp_____Auto_____Lien_____

Patient Responsibility, Assignment of Insurance Benefits, Release of Information, & Notice of Privacy Practices

I understand that I am financially responsible for all charges owed under insurance contracts and fully responsible for non-contracted and non-authorized services. All charges owed are payable at the time services are rendered including insurance deductibles, co-payments, and non-contracted services. I authorize my insurance company to issue payment directly to my medical provider for all medical benefits payable to me for services rendered to me or my dependent. I authorize release of any information necessary to obtain such payment. I agree to pay all costs of collection including attorney's fees. I acknowledge all information on the Notice of Privacy Practices webpage of www.drsheps.com and I may receive a hard copy upon my request.

Signature_____Date_____