

Patient Registration Form

Patient name (Last name, first name, middle initial)

Mailing address

City State Zip

Date of Birth Age

Height Weight Sex Male
 Female

Employer name _____
Employer address _____

Name of nearest relative/
person to call in case of
emergency (other than
someone living in your home) _____

Today's date

Telephone numbers
Home _____
Work _____
Cell _____

Social Security Number _____

Marital status Single Married
 Widowed Divorced
 Partnered

Spouse's name _____

Primary care
physician _____

Telephone

Insurance Information

Complete name and
address of insured/
responsible party _____

Social Security Number _____

Employer _____

Name of Insurance Company _____
Policy Number _____
Group Name _____
Group Number _____

Are you enrolled in an Yes
HMO? No

Indiana Medicaid Number

Relationship
to patient _____

Date of Birth _____

Medicare Number

Medicare
Supplement _____
Policy Number _____

Is this a Medicare Yes
Replacement policy? No

I request that payment of authorized benefits be made on my behalf to Stephen F. Mitros, M.D. for any services provided. I authorize the release of any medical or other information necessary to process charges related to my treatment by Stephen F. Mitros, M.D.

Patient signature

Who referred you
to this office? _____

ALLERGIES _____

