Dr. Stanley Bunas

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Nickname:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone : ( )
City: State: Zip Code:		Cell phone :
Occupation: Employer:		Employer phone: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone : ( )

Name of primary insurance:	
Policy no.:	Group no.:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Co-payment: $

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

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

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

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone: ( )	Work phone: ( )

By signing below, I acknowledge that I am responsible for any charges incurred today and on subsequent visits. This particularly includes my deductibles, my co-pays, and any charges for which my Insurance Company denies payment, especially if the denial is caused by an absent Referral Authorization Form, or my lack of response to a request for information, or expired or ineligible coverage. I authorize my Insurance Company to pay Dr. Bunas directly for my treatment. I authorize Dr Bunas to provide my Insurance Company the information required to process these claims. After my Insurance Company has paid their portion of my charges, I agree to pay my portion within 30 days of billing. If not, I agree to pay a 1-1/2% late fee and a $5 rebilling fee.

Patient/Guardian signature *Date*

**I have received the "Medical Records Privacy Notice". *Initials*: ________________