Registration Form.

Dr. Rick J. Unsell, LLC

PATIENT INFORMATION

Name

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Last Name **First Name** **Middle Name** **Maiden Name**

Address ____**Home Phone** ______

Street **City and State** **Zip Code**

Fax _______________ **Pager** ________________ **Mobile Phone** ________________ **E-Mail** ________________

Birthdate ___________ **Age** _______ **Marital Status** S M W D **SS#** __________________________

Employed by _______________________**Occupation** ___________________ **Work Phone** _________________

Address____

Street **City and State** **Zip Code**

Spouse's Name ____ **Spouse's SS#** ___________________________

Spouse's Employer _______________________________________**Spouse's Work Phone** ___________________

Referred by____

INFORMATION ON PERSON RESPONSIBLE FOR BILL

Guarantor Name _____________________________**SS#**_______________**Relationship to Patient**_____________

Address ____

Home Phone No. ____**Work Phone No.** ________________________

Employed By ______________________________ **How Long?** _______ **Occupation** _______________________

INSURANCE INFORMATION

Do you have insurance to cover the fees for services rendered? Yes No

PRIMARY INSURANCE		SECONDARY INSURANCE	
Name of Insured		Name of Insured	
Primary Insurance		Secondary Insurance	
Primary Ins Address		Sec Ins Address	
Identification #		Identification #	
Group #	Eff. Date	Group #	Eff. Date
Insured's DOB		Insured's DOB	

AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical information necessary to process this claim. Additionally, I request payment of my Medicare benefits to the party who accepts assignment.

I authorize payment of medical benefits to Dr. Stephen Christy or Dr. Rick J. Unsell for services performed. I understand that I am responsible for payment regardless of insurance coverage and if my insurance does not pay within 60 days I will be billed in full for my treatment.

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Signed **Date**

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Signed **Date**