Patient Registration

Date: _____

Patient Information (please complete using your name as listed on your insurance card)

First Name: _____ Middle Initial: _____ Last Name: _____
Address: _____ Apt/Floor:____ City: _____ State: ____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Date of birth: _____ SS# _____ Email:_____

Sex: M _____ F _____ Occupation: _____Employer: _____

Insurance Responsibility – Policy holder Information. If patient is policyholder, please disregard this section.

First Name: _____ Middle Initial: _____ Last Name: _____
Address: _____Apt/Floor:_____
City: _____ _____State: _____Zip Code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____
Date of birth: _____ SS# _____ Sex: M _____ F _____
Occupation: _____ Employer: _____

Insurance Information
All Patients must provide a copy of their insurance card at the time of their visits.
Primary Insurance: _____Name of Insured: _____ Relationship: _____
Insured's DOB: _____ Policy # _____ Group # _____
Secondary Insurance: _____Name of Insured: _____ Relationship: _____
Insured's DOB: _____ Policy # _____ Group # _____

Referring Physician Information
Referring Physician: _____ Phone # _____
Primary Care: _____Phone # _____

AUTHORIZATION FOR MINOR TO BE SEEN WITHOUT GUARDIAN PRESENT: **I** _____ **(name)** authorize my child _____**(minor name)** to be seen and receive treatment at Bobby Buka MD PC without my presence.

Emergency Contact Information
Name: _____ Relationship: _____ Phone: _____

Credit Card Authorization: You will be asked to leave a credit card number at the time of check in. This information will be stored securely until the time when your insurances have paid their portion and notified us of any member responsibilities. At that time any remaining balance owed will be charged to the card on file. Please note that this will NOT compromise your ability to dispute charges or your insurance company's determination of payment.

I, _____ (name) Authorize Bobby Buka MD PC to charge outstanding balances to the following card:

	ACCOUNT NUMBER:	EXPIRATION DATE:
VISA		
MASTERCARD		
AMERICAN EXPRESS		

I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare) for purpose of filing and payment of medical claims. I authorize payment of medical benefits of the provider.

Signature: _____ Date: _____