



~ Registration Form ~

101 W. Cherry St, 1st Floor, Palmyra, PA 17078

Patient Information:

Date: _____

Name: _____
Last Name First Name Middle Initial

Address: _____

City: _____ State: _____ Zip Code _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Email Address: _____

Sex: [] Male [] Female Age: _____ Date Of Birth: _____

Status: [] Single [] Married [] Separated [] Widowed [] Divorced [] Minor
[] Other _____

Employer/School: _____

Occupation: _____ Employer/School Phone: (_____) _____

In Case Of Emergency who should be notified? _____

Emergency Contact Phone: (_____) _____ Relationship to patient: _____

How did you hear about us? _____

Primary Insurance:

Is the patient listed above the primary insurance holder? [] Yes [] No

If No, Policy Holder Name: _____
Last Name First Name Middle Initial

Policy Holder Date of Birth: _____ Relationship _____

Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Jeffrey J. Backenstoets, D.O., DBA Capstone Medical Associates, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient