CAPSTONE
MEDICAL WELLNESS CENTER

~ Registration Form ~

4807 Jonestown Road, Suite 141, Harrisburg PA 17109

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. Backenstoes, 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