



- NEW PATIENT
- NEW OB
- NAME CHANGE
- ADDRESS CHANGE
- INS. CHANGE
- UPDATE

VALERIE SCHOLTEN, M.D.

**Most insurance carriers require us to submit claims for patient services. For this reason, we request all patients to fill out completely and sign the registration form on an annual basis. If you are mailing this form please return ALL copies. THANK YOU**

**PRESS FIRMLY – 2 PART FORM**

**PATIENT INFORMATION**

Patient's Legal Name \_\_\_\_\_ Birth Date \_\_\_\_\_ S.S. # \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_ Daytime Phone # (\_\_\_\_) \_\_\_\_\_ Marital Status \_\_\_\_\_  
Street City Zip Area Code

Employer's Name \_\_\_\_\_ Occupation (Indicate if Student) \_\_\_\_\_ Business Phone # (\_\_\_\_) \_\_\_\_\_  
Area Code

Patient's Primary Doctor \_\_\_\_\_ Drs. Phone # (\_\_\_\_) \_\_\_\_\_  
Name Street City/St Zip Area Code

Name, Address of Nearest Friend or Relative \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_  
Area Code

**PARENT / SPOUSE INFORMATION**

Parent / Spouse Name \_\_\_\_\_ Birth Date \_\_\_\_\_ SS# \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_  
Street City Zip

Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_

**PRESS FIRMLY – 2 PART FORM**

**PRIMARY INSURANCE**

Ins. Company Name \_\_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_

ID#/Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Relationship to PT. \_\_\_\_\_ Birthdate \_\_\_\_\_

Policy Holder's Address \_\_\_\_\_ Home Phone \_\_\_\_\_

**SECONDARY INSURANCE**

Other Insurance Co. \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Other Insured (If other than patient) \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Birth Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ ID #/Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Other Insured's Employer \_\_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS**

I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted and I will be bound by the signature as though I personally signed the claim. I also authorize the release of any medical information necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedures.

\*

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Date