CRAIG G. BURKHART, M.D., Inc.

Patient Registration Information

PRINT LEGIBLY and complete ALL sections

PATIENT'S INFORMATION

Name_____ DOB_____ AGE_____ Sex: **M F**

Address_____ Apt/Lot_____

City_____ State_____ Zip_____ County_____

Marital Status: **M S D W** Race_____ SocSec#_____

Phone/Cell_____ Phone _____

Employer's Name_____ Occupation_____

Address_____ City_____

State_____ Zip_____ Work Phone_____

Spouse's Name_____ Phone_____

DOCTOR REFERRED BY_____ Phone_____

INSURANCE INFORMATION-------FILL OUT INSURED'S NAME AND DOB ONLY UNLESS CARDS ARE NOT PRESENT

Primary Ins _____ **Name of Insured**_____ **DOB**_____

Relationship to patient_____ ID#_____ Group#_____

Secondary Ins_____ **Name of Insured**_____ **DOB**_____

Relationship to patient_____ ID#_____ Group#_____

EMERGENCY CONTACT INFORMATION

Name_____ Phone_____

PARENT or GUARDIAN FILLING OUT THIS FORM AND REQUESTING TREATMENT - FOR MINORS OR ADULT WARDS

Name_____ DOB_____ SSN_____

Relationship to patient_____ Phone_____

FINANCIAL RESPONSIBILITY FOR PATIENTS AND MINOR CHILDREN OR ADULT WARDS

Payment of the bill and Release of information necessary to process claim rests with the person who is requesting services and signs this form.

SIGNATURE OF PATIENT or GUARDIAN _____ **Date:** _____