

PATIENT REGISTRATION FORM

Gregory J. Liebscher, MD, P.C.

(Print clearly & press firmly in black ink)

Today's Date _____

Patient Name _____
Last First MI Nickname

Date of Birth _____ Age _____ SSN _____ Gender (circle) F M

Address _____
Street Apt/Ste City State Zip

E-Mail _____

Primary Phone () _____ May we leave a message? (circle) YES / NO

Secondary Phone () _____ May we leave a message? (circle) YES / NO

Work Phone () _____ OK to call work? (circle) YES / NO

Patient's Employer _____

Primary reason for today's visit _____

Primary Care Physician _____ Referring Physician _____
Last First Last First

Is this work-related? (circle) YES NO Related to an auto accident? (circle) YES NO *If YES on EITHER, please complete Auto/WC Form*

Current insurance card(s) and photo identification are required for scanning. Please complete the following:

Primary Insurance _____ Policy #/ID _____ Group # _____

Name of Policy Holder _____ SSN _____ Date of Birth _____ Gender (circle) F M

Relationship to Patient _____ Employer _____ Employer Phone () _____

Secondary Insurance _____ Policy #/ID _____ Group # _____

Name of Policy Holder _____ SSN _____ Date of Birth _____ Gender (circle) F M

Relationship to Patient _____ Employer _____ Employer Phone () _____

If you are a Medicare beneficiary, please circle any of the following that apply to you:

(circle) Working-Aged ESRD Auto/Med/No Fault Liability Workers Comp Federal Black Lung Veterans Affairs Disability Other Liability

If you do not have insurance, have you applied for government assistance? (circle) YES NO *If yes, provide social worker's information.*

Social Worker's Name _____ Phone () _____

If patient is a minor, name of Custodial Parent _____

Custodial Parent's Primary Phone() _____ Secondary Phone() _____

Custodial Parent's SSN _____ Date of Birth _____

Emergency Contact – Close friend or relative not living with you that we can contact in an emergency:

Name _____ Relationship _____ Phone() _____
Last First

Name of person we may speak with other than yourself regarding your medical care? _____

Primary Phone() _____ Secondary Phone() _____ Relationship _____