# PATIENT REGISTRATION FORM

# GREGORY J. LIEBSCHER, M.D, P.C

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Today's Date_____

Patient Name_____
Last First MI Nickname

Date of Birth_____ Age_____ SSN_____-_____-_____ Gender (circle) M / F Marital Status_____

Address_____
Street Apt # City State Zip

Primary Phone_____ Secondary Phone_____ May we leave a message? (circle) Y / N

Patient's Employer_____ Email Address _____

Primary Reason for Visit _____

Primary Care Physician_____ Referring Physician_____

Preferred Pharmacy_____
Name Location Phone Number

Is this a work-related accident? (circle) Y / N Is this related to an auto accident? (circle) Y / N If YES on EITHER, please complete the Auto/ WC Form

How did you hear about our office? _____

*** Please complete this section if your visit is insurance related. Current Insurance Cards and photo identification are required

Primary Insurance_____ Subscriber ID #_____ Group #_____

Name of Policy Holder_____ SSN_____-_____-_____ Date of Birth_____ Gender M / F

Relation to Patient _____ Employer_____ Employer Phone # _____

Secondary Insurance_____ Subscriber ID #_____ Group #_____

Name of Policy Holder_____ SSN_____-_____-_____ Bate of Birth_____ Gender M / F

Relation to Patient _____ Employer_____ Employer Phone # _____

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

Working-Aged ESRD Auto/Med/No Fault Liab Workers Comp Federal Black Lung Veterans Affairs Disability Other Liablilty

Emergency Contact

Name_____ Relationship_____ Phone Number_____

May we speak with them regarding your medical care? (circle one) Y / Special Instructions_____

Name of person not living with you that we may contact in an emergency

Name_____ Relationship_____ Phone Number_____

May we speak with them regarding your medical care? (circle one) Y / Special Instructions_____

_____ (initial) I understand I am entitled to our HIPPA regulations (Available by request any time).

_____ (initial) Insurance Carriers pay benefits for services preformed for functional reasons. Therefore I understand that my insurance carrier may or may not, approve/ pay for particular procedures that I may choose to have preformed. I understand that Dr. Liebscher's office does not bill insurance for cosmetic procedures. If I choose to submit a claim to my insurance its on my own.

_____ (initial) I understand Dr. Liebscher's office will not provide insurance codes/ billing for any cosmetic surgery.

_____ (initial) I understand I am financially responsible for any and all services I receive by Dr. Liebscher's office that are not covered by insurance, and payment is due at time of service.

_____ _____

Patient Signature Date