

**Mark Holbreich, M.D.**

8902 N. Meridian St. Indianapolis, IN 46260 317-574-0230

### Patient Registration

Patient's Name \_\_\_\_\_  
Last First Middle DOB

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Area Code-Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

Marital Status \_\_\_\_\_ Sex M \_\_\_ F \_\_\_ Patient's SS# \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Work # \_\_\_\_\_

Primary Care Provider \_\_\_\_\_ Office Phone # \_\_\_\_\_

Referring Provider \_\_\_\_\_ Office Phone # \_\_\_\_\_

*If applies, please complete following:*

Father's Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Nearest Relative for Emergency \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

#### RESPONSIBLE PARTY INFORMATION

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Responsible Party's SS# \_\_\_\_\_

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

#### INSURANCE INFORMATION

Primary Carrier \_\_\_\_\_

Plan Number \_\_\_\_\_ Group Number \_\_\_\_\_

Secondary Carrier \_\_\_\_\_

Plan Number \_\_\_\_\_ Group Number \_\_\_\_\_

**IMPORTANT: Please contact your insurance carrier to find out if a referral is required. Laboratory testing and/or X-rays may be necessary. Please check which lab/X-ray facilities are contracted with your insurance carrier.**

**REFERRAL REQUIRED: Yes \_\_\_\_\_ No \_\_\_\_\_**

**Laboratory contracted with carrier: Mid-America \_\_\_\_\_ South Bend \_\_\_\_\_ Other \_\_\_\_\_**

**Radiology contracted with carrier: Northwest \_\_\_\_\_ CDI \_\_\_\_\_ Methodist \_\_\_\_\_ Other \_\_\_\_\_**

Authorization is hereby given to release any information to and receive a direct payment from the insurance company covering services. I understand that I am financially responsible for the charges not covered by this authorization. In the event that the services provided are not covered by my insurance policy/company I will be responsible for all charges.

Insured or Authorized Signature \_\_\_\_\_ Date: \_\_\_\_\_