

MELISSA J. THIEL, M.D., P.C.

PATIENT REGISTRATION (PLEASE PRINT)

Last Name _____ First _____ MI _____

Address _____

City _____ ST _____ ZIP _____ Marital Status: S M D W

PT SSN _____ - _____ - _____ Date of Birth _____

Home Phone _____ Work Phone _____

Cell Phone _____ Fax (Home) _____

Email Address _____

Please indicate (*) the two numbers you would like us to keep in our computer.

INSURANCE INFORMATION (If same as patient, write self)

Primary Insurance

Name of Policy Holder _____

Date of Birth _____ SSN _____ - _____ - _____

Name of Employer _____ Phone _____

Name of Insurance _____

Address of Insurance _____

Insurance Phone _____

POLICY # _____ GROUP# _____

Referral

Who may we thank for referring you?

Friend _____ Doctor _____ Other _____

ASSIGNMENT OF BENEFITS

I, the undersigned certify that I (or my dependent) have coverage with _____ and assign directly to **Melissa J. Thiel M.D., P.C.** all insurance benefits, payable to me for services rendered if claim is submitted by Dr. Thiel's office. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____ Date _____

Review:

Date							
Initial							