ROBERT W. EITCHES, M.D.
MAXINE BAUM, M.D.

PLEASE PRINT

PATIENT REGISTRATION

PATIENT'S ACCOUNT#	CATEGORY	RESPONSIBLE PARTY	E-MAIL	LICENSE #

PATIENTS NAME (LAST, FIRST, INIT.)	DATE OF BIRTH	AGE	SEX (M/F)

BEST DAYTIME NUMBER	CELL PHONE NO.	HOME PHONE NO.	WORK PHONE NO.

ADDRESS	CITY	STATE	ZIP CODE

SOCIAL SECURITY NO.	REFERRED BY: PATIENT/M.D./OTHER	ADDRESS

OCCUPATION	EMPLOYER	MARITAL STATUS S / M / D / W / P

EMERGENCY CONTACT/RELATIONSHIP	DAYTIME PHONE/CELL PHONE

PRIMARY INS. INFO. PLEASE PROVIDE COPY....	INSURED'S NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT

INSURANCE CO. NAME & ADDRESS

SUBSCRIBER NO.	GROUP NO.	EFFECTIVE DATE	CO-PAYMENT AMOUNT $

INSURED'S EMPLOYER AND OCCUPATION	WORK PHONE

SECONDARY INS. INFO. PLEASE PROVIDE COPY....	INSURED'S NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT

INSURANCE CO. NAME & ADDRESS

SUBSCRIBER NO.	GROUP NO.	EFFECTIVE DATE	CO-PAYMENT AMOUNT $

INSURED'S EMPLOYER AND OCCUPATION	WORK PHONE

OTHER FAMILY MEMBERS WHO HAVE BEEN SEEN IN THIS OFFICE ____________________

NAME OF SPOUSE (HUSBAND, WIFE or DOMESTIC PARTNER) ____________________

OCCUPATION ____________ EMPLOYER ____________ WORK PHONE ____________

IF PATIENT IS A MINOR OR STUDENT:

MOTHER'S NAME ____________________ HOME PHONE ____________

HOME ADDRESS ____________________

OCCUPATION ____________ EMPLOYER ____________ WORK PHONE ____________

FATHER'S NAME ____________________ HOME PHONE ____________

HOME ADDRESS ____________________

OCCUPATION ____________ EMPLOYER ____________ WORK PHONE ____________

PAYMENT OF SERVICES: **CASH** ________ **CHECK** ________ **MASTERCARD** ________ **VISA** ________

Patients are financially responsible for all services rendered and not dependent upon insurance coverage. We will, however, assist you in making a claim to your insurance company to help you recover the cost of medical services.

I hereby authorize Robert W. Eitches, M.D. (provider) to release to my insurance company or its representative, any medical information necessary (including diagnosis and the records of any treatment or exam rendered to me during the period of such medical care) to process this claim.

I authorize and request ____________________ insurance company to pay directly to Robert W. Eitches, M.D. for medical services rendered.

______________________ ______________________ ______________

PATIENT **SIGNATURE** **DATE**