SHEILA A. BOND, MD.,PC

WELCOME, PLEASE TAKE A FEW MINUTES TO ANSWER THE QUESTIONS ON BOTH SIDES OF THIS FORM SO WE CAN BETTER ASSIST YOU WITH YOUR HEALTH CARE NEEDS.

PATIENT REGISTRATION INFORMATION

Date_____ **SS#**_____ **DOB**_____ **Age**_____ **Sex: ( )M ( )F**

Name_____
Last Name **First Name** **Middle Initial**

Address_____
Street **City** **State** **Zip Code**

Home Phone_____ **Cellular Phone#**_____ **Email Address**_____

Marital Status: ( )Minor ( )Single ( )Married ( )Divorced ( )Widowed ( )Separated

Employer_____**Occupation**_____

Business Address_____**Business Phone**_____

Whom may we thank for this referral?_____

In case of emergency, whom should we contact?_____ **Phone No.**_____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT

I _____

Acknowledge that a copy of Dr. Bond's Privacy Practices has been made available to me.

_____
Signature of Patient **Date**

Who will you allow us to share medical information with?

_____
Name **Relation** **Phone Number**

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Sheila A. Bond, MD all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf.

I authorize the above noted physician and/or any provider or supplier in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party_____ **Date**_____