J. Michael Herr, DO, LLC
Patient Registration Form

Name _____ Date ____/____/____

Street Address _____

City/State/Zip code _____

Date of Birth ___ / ___ / ____ Email_____

Home phone (___) - ___ - _____ ; Work phone (___) - ___ - _____ ; Cell - (___) - ____ - _____

Preferred method of communication _____

May we leave messages on your answering machine? Yes No ; test results? Yes No

May we speak with your spouse or significant other regarding your treatment? Yes No N/A

Spouse - _____ ; Child - _____ ; Other - _____

Primary insurance _____ ID # - _____

Relation of Patient to Insured; self spouse child (If not Self, name & DOB) _____

Secondary Insurance _____ ID # - _____

Primary Care Provider - _____ Phone - (____) - ____ - _____

Preferred Language_____ Ethnicity/Race_____

Emergency Contact - _____Relationship _____

Phone - (____) - ____ - _____ Address_____

YourOccupation _____

Employer (or none) _____ Phone - (____) - ____ - _____

ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize direct payment of medical benefits to Dr. Herr for services rendered by him. I understand that, regardless of my insurance status, I am financially responsible for the balance not covered by my insurance. I hereby authorize Dr. Herr to release any medical or other information necessary to process claims for payment. I authorize the use of my signature below on all my insurance submissions. I certify that the information above is true and correct to the best of my knowledge and I will notify Dr. Herr of any change in my status or in the information above.

_____ Date - ___ / ___ / _____

Patient / Parent / Guardian Signature