PLUNDO MEDICAL ASSOCIATES, OSTEOPATHIC, P.C.
518 PELLIS ROAD
GREENSBURG, PA 15601
724-830-2570

PATIENT REGISTRATION

REFERRED BY: ____________________ DATE: _______________

NAME: _________________________ ____________________ _______________________
(LAST) (FIRST) (MIDDLE)

STREET ADDRESS: ____

CITY: __________________ COUNTY: _____________________ STATE: ____________________

ZIP CODE: _________________

SSN__________________ BIRTHDATE: _____________ MARITAL STATUS: ________________

HOME PHONE: _________________ WORK PHONE: _______________

CELL PHONE: ___________________

E-MAIL: ____

EMPLOYER: ____

STREET ADDRESS: _______________________________________

CITY: __________________ STATE: _______________ ZIP CODE: _______

EMERGENCY CONTACT: _______________________

RELATIONSHIP: ____________________ PHONE: _________________

IF PATIENT NOT RESPONSIBLE FOR THE BILL; PLEASE INDICATE WHO IS RESPONSIBLE:

NAME: ____________________________ RELATIONSHIP: _____________

MAILING ADDRESS: _______________________________________

CITY: ___________________ STATE: ____________ ZIP CODE: ________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION & CLAIM PAYMENT:

1. I HEREBY AUTHORIZE PLUNDO MEDICAL ASSOC. TO RELEASE ANY INFORMATION REGARDING SERVICES RENDERED AND ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO FILE INSURANCE.
2. I HEREBY AUTHORIZE AND DIRECT MY INSURER TO ISSUE PAYMENT CHECK(S) FOR BENEFITS DUE ME FOR SERVICES RENDERED BY PLUNDO MEDICAL ASSOC. TO BE MADE DIRECTLY TO OFFICE. REGARDLESS OF MY INSURANCE BENEFITS, IF ANY, **I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE FEE FOR SERVICES RENDERED.**
3. **ALL CO-PAYS OR PRIVATE CHARGES ARE DUE AT THE TIME OF SERVICE.**

PATIENT SIGNATURE: ____ **DATE:** _________________