Welcome to our Office **Patient Registration** ***Confidential***

Today's Date_____ Age_____ Date of Birth, Month_____ Day_____ Year_____

Patient name_____

Address_____

City_____ State_____ Zip_____

Home phone_____ Cellphone_____ Work phone_____

Driver License #_____ State_____ S.S.#_____

Sex M / F Marital status S / M / W / D / SEP Referred by_____

Patient's employer _____ Occupation_____

Work address_____

Spouse/Guardian name_____ Date of birth_____

Name of employer_____ Phone work (_____)_____

Employer address_____

Emergency contact name/relationship_____ Phone_____
(Other than Spouse)

Payment Required at Time of Service. I will be paying today by Cash_____ Check_____ MasterCard or Visa_____

Primary Insured_____ Date of birth_____

Primary Ins_____ Phone_____ Relation to patient_____

Group#_____ ID#_____

Consent to Treatment Assignment of Benefits

I certify that the information given by me in applying for payment is correct. I authorize George J Juetersonke DO PC or his staff to release any medical records or information that may be necessary for either medical care or processing applications for financial benefit. I understand that my **insurance may not reimburse me** for all or any expenses incurred. I further understand and agree to be ultimately responsible for the balance on my account for any services rendered. I understand that Medicare usually does **not** pay for services from this office. A photocopy of this assignment shall be as valid as the original.

I am consulting the Physician and or the Nurse Practitioner as a patient and hereby consent to treatment by the staff. The medical history and information given above is true and is presented for the sole purpose of obtaining medical counsel and treatment. As part of my medical record my photograph will be taken. It along with the above information is considered confidential. I am aware that the practice of medicine is not an exact science and I expressly acknowledge that there have been **no guarantees** made to me as to the benefits or lack of complications from treatment. **I will notify the office of any changes in the above information or my health status as they occur**. It is my responsibility to make a **follow-up appointment** in six weeks from today's appointment unless directed otherwise.

_____

Patient signature here Guardian's signature if pt is a minor **Todays Date**

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Updates only. Please do **not** sign here until directed to do so. Do **not** date here until directed. Date