PATIENT REGISTRATION
FOR
GORDON J. SHUMATE, DPM

?ATIENT INFORMATION

☐Mr. ☐Mrs. ☐Ms ☐Other ________

.AST NAME FIRST NAME M.I. BIRTH DATE SOCIAL SECURITY NUMBER

ɛESIDENCE ADDRESS STREET CITY STATE ZIP TELEPHONE NUMBER

ɪAILING ADDRESS (if different from above)

ɪARITAL STATUS OCCUPATION EMPLOYER / SCHOOL

MPLOYER ADDRESS STREET CITY STATE ZIP TELEPHONE NUMBER

ɜPOUSE OR PARENT / GUARDIAN INFORMATION

AST NAME FIRST NAME M.I. RELATIONSHIP TO PATIENT

ɪAILING ADDRESS STREET CITY STATE ZIP TELEPHONE NUMBER

OCIAL SECURITY NUMBER OCCUPATION EMPLOYER

MPLOYER ADDRESS STREET CITY STATE ZIP TELEPHONE NUMBER

NSURANCE INFORMATION

RIMARY INSURANCE COMPANY – NAME AND ADDRESS

ɪAME OF INSURED PERSON BIRTH DATE RELATION TO PATIENT POLICY NUMBER GROUP NUMBER

ECONDARY INSURANCE COMPANY – NAME AND ADDRESS

ɪAME OF INSURED PERSON BIRTH DATE RELATION TO PATIENT POLICY NUMBER GROUP NUMBER

'RIMARY CARE PHYSICIAN INFORMATION

OCTOR'S NAME TELEPHONE NUMBER

TREET ADDRESS CITY STATE ZIP

ɪ GENERAL, FOR WHAT DOES THIS PHYSICAN TREAT YOU? ________________________________

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.EFERRAL INFORMATION

OW WERE YOU REFERRED TO OUR OFFICE? ☐DOCTOR ☐PATIENT ☐YELLOW PAGES ☐OTHER ________

☐PATIENT INSURANCE AUTHORIZATION

hereby authorize the processing of the medical insurance either by electronic or manual method by the sted provider below. My signature authorizes payment of all major medical and/or surgical benefits to hich I am entitled from the listed insurer below to pay Gordon J. Shumate, DPM. I further authorize ordon J. Shumate, DPM to release all medical and/or insurance claim information necessary to secure the ayment(s). I recognize my financial obligation of any co-insurance or deductible, and non-covered services iat may be required. This agreement will remain in effect until revoked by me in writing. A copy of this ocument is considered as valid as an original.

ATIENT'S SIGNATURE ______________________ DATE ______________

☐MEDICARE AUTHORIZATION

request that payment of authorized Medicare benefits be made on my behalf to Gordon J. Shumate, DPM r any services furnished. I authorize any holder of medical information about me to release to Medicare nd its agents any information needed to determine these benefits or the benefits payable to related services.

request payment of authorized Medigap benefits be made to Gordon J. Shumate, DPM and also authorize y holder of medical information about me to release to my named Medigap Insurer any information eeded to determine benefits payable for services from this provider.

understand my signature below requests that payment be made and authorizes release of medical formation necessary to pay the claim. If "other health insurance" is indicated in Block 9 of the HCFA-1500 rm, or elsewhere on other approved claim forms or electronically submitted claims, my signature thorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the rovider or supplier agrees to accept the charge determination if the Medicare Carrier as the full charge, and e patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and e deductible are based upon the charge determination of the Medicare Carrier.

TIENT'S SIGNATURE ______________________ DATE ______________

OFFICE USE

Primary Care Physician UPIN ______________

Notes: ______________________________________

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☐HIPAA Acknowledgement signed

☐Billing Information Forwarded