REGISTRATION FORM

ANTHONY C. ZWAAN, MD
FAMILY PRACTICE
19 Hampton Road, Suite One, Exeter, NH 03833
603-773-2225

*****Please complete and return on your first visit or mail back to us*****

PATIENT INFORMATION

Last Name _____ **First** _____ **Middle** _____

Date of Birth ____ / ____ / _____ **Social Security** _____ **Sex** □ M □ F **Marital Status** □ S □ M □ D □ W

Mailing Address _____ **City** _____ **State** _____ **Zip Code** _____

Home Phone _____ **Mobile Phone** _____ **Email** _____

Occupation _____ **Employer** _____ **Work Phone** _____

May we contact you at work? □ Yes □ No **Pharmacy Name/Location** _____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

□ **Family** □ **Friend** □ **Ad** □ **Phone Book** □ **Location** □ **Hospital** □ **Insurance** □ **Dr**_____ □ **Other**_____

CONTACT INFORMATION

Person to notify _____ **Relationship** _____

Home Phone _____ **Mobile Phone** _____ **Work Phone** _____

Contact this person for □ emergency only □ routine medical information (labs, appointments, prescriptions) **Please initial:** _____

Other Physicians (involved in my care**):** _____ **OK to contact** □ Y □ N **Please initial:** _____

_____ **OK to contact** □ Y □ N **Please initial:** _____

_____ **OK to contact** □ Y □ N **Please initial:** _____

INSURANCE INFORMATION-Please present *all* (cards) at each visit.

It is your responsibility to provide valid and up to date insurance information.

□ **Self Pay**
Payment is Due on Date of Service

□ **Workers' Compensation**
Date of injury:_____
Authorization:_____

□ **Automobile Accident**
Date of injury:_____
Location (State):_____

Primary Insurance	**Secondary Insurance**
Insurance	**Insurance**
ID # **Group #**	**ID #** **Group #**
Co-pay **Deductible**	**Co-pay** **Deductible**
Policy Holder □ **self** continue to other side □ **other** complete below	**Policy Holder** □ **self** continue to other side □ **other** complete below
***Guarantor's* Name**	***Guarantor's* Name**
DOB / / Relationship to Patient	**DOB / / Relationship to Patient**
Address (if different)	**Address** (if different)
City **State** **Zip Code**	**City** **State** **Zip Code**
Phone **SS#**	**Phone** **SS#**
Employer	**Employer**

*** Form Continues on the Other Side***

AUTHORIZATIONS

General Consent for Treatment

I hereby give my consent to Anthony C. Zwaan, MD for the evaluation and treatment of me on an on-going basis. I understand that I have the right to revoke this consent in writing, at any time, except when the physician or other clinical personnel have already taken action on my consent. I certify that the information on the previous page is true and complete.

Signature of Patient or Personal Representative Date

Print name of Signature Personal Representative's Authority

Assignment of Insurance Benefits and Release of Medical Information

I hereby authorize any insurance benefits to be paid directly to the physician providing services. I also authorize the physician or any holder of medical information to release any information necessary to process an insurance claim. It is the patient's responsibility to check with his/her insurance company regarding coverage. For contracted insurances, we will submit claims on your behalf. It is also the patient's responsibility to pay for all non-covered services. Any remaining balances are due 30 days after the insurance payment. Co-payments are due at time of service. Balances past 30 days are subject to an additional billing fee and interest.

Signature of Patient or Personal Representative Date

Print name of Signature Personal Representative's Authority

Acknowledgement of Receipt of Privacy Practices

I, the undersigned, understand that medical providers are required by law to maintain the privacy of protected health information and provide me a notice of their legal duties and privacy practices regarding health information about me. My signature below attests that I have read, understood, and agree with the Notice of Privacy Practices that describes how medical information about me may be used and disclosed and how I can have access to the information.

Signature of Patient or Personal Representative Date

Print name of Signature Personal Representative's Authority

Consent to Treat a Minor

Anthony C. Zwaan, MD must have permission from the parent or legal guardian before an evaluation or any medical treatment can be given to a minor (a person under the age of 18).

I hereby give my consent to Anthony C. Zwaan, MD for the evaluation and treatment of ________________________________, a minor, age______, born___________, on an on-going basis.

Father's Name____Mother's Name____

Signature Relationship Date

****OPTIONAL: I declare that ____________________________ is an emancipated minor, and hereby consent to treatment without my presence on an on-going basis.**

Signature Relationship Date

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