David J. Fuerst, MD Inc.
Patient Registration Form

Patient Information

Patient Name:_____ Social Security #:_____

Address: _____ Email Address:_____

City:_____ State: _____ Zip Code: _____

Date of Birth: _____ Male: ☐ Female: ☐

Home Phone: (___)_____ Work Phone: (___)_____

Emergency contact:_____ Relation: _____Phone: _____

Additional Information

Primary Care Physician: _____ Phone:_____

How did you hear about Dr. Fuerst? Phone Book ☐ Friend ☐ Insurance Co. ☐

Referred by:_____ ☐ Other (please describe)_____

Primary Insurance Information

***** PLEASE PROVIDE FRONT DESK WITH INSURANCE CARDS AND IDENTIFICATION*****

Insurance Company: _____

Name of Insured: _____ Insured Date of Birth: _____

Relation to Patient: (please check one) Self ☐ Spouse ☐ Parent/Guardian ☐ Other ☐

Secondary Insurance/ Vision Care Plan Information

Insurance Company: _____

Name of Insured: _____ Insured Date of Birth: _____

Relation to Patient: (please check one) Self ☐ Spouse ☐ Parent/Guardian ☐ Other ☐

Authorization for Treatment and Release of Medical Records

I hereby authorize David Fuerst, MD and assistants to treat me. Also by signing below I am authorizing David Fuerst, MD to furnish the above insurance company (ies) all the necessary information that they may request. It is the policy of David Fuerst, MD Inc. to require payment at the time services are provided. In the event that patient is in a prepaid plan only the co-payment is applicable. By signing below I am stating that I understand this policy. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediate carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment below.

I hereby irrevocably assign to the doctor all payments for medical services rendered and ALL MAJOR MEDICAL BENEFITS, from my insurance company (ies) and Medicare.

X _____ ___/___/___ X_____ ___/___/___

Patient Signature Date Parent/Guardian Date