Registration Sheet

Last Name: ______________________ First Name: ________________________ MI: ____

DOB:____________ Gender: ___ SSN: _________________Marital Status: ____________

Spouse's Name: __________________________ Street Address: ____________________

City: ________________ State: ___ Zip Code: ___________Home Phone: _____________

Cell Phone: ______________ Work Phone: ___________ E-mail: ____________________

Emergency Contact: ___________________ Phone Number: ______________________

Assignment of Benefits:
I request payment of medical benefits be made on my behalf to Dr. Jonathan Richard, M.D. for any services performed by him. I authorize any holder of medical information about me to release to the insurance carrier or Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature: _____________________________ Date: __________________