REGISTRATION
(PLEASE PRINT)

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Date: _____ Home Phone ( ) _____ Cell Phone ( ) _____

PATIENT INFORMATION

Name _____ Social Security # _____
Last Name First Name Middle Initial

Address_____ Email _____

City _____ State _____ Zip Code _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Single ☐ Divorced ☐ Partnered _____years

Patient's Employer _____ Occupation _____

How did you hear about Dr. Kristiansen ? _____

In case of emergency, who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person responsible for account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Social Security # _____

Person Responsible Employed by _____ Occupation _____

Insurance Company _____ Phone Number (____) _____

Member ID Number_____ Group Number _____

Names of dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Subscriber Employed by _____ Business Phone (___) _____

Insurance Company _____ Social Security # _____

Member ID Number _____ Group Number _____

ASSIGNMENT AND RELEASE

I certify that I, and or my dependent(s), have insurance coverage with _____ and assign them directly to
Name of Insurance Company(ies)
Dr. Kristiansen all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all Charges whether or not paid by insurance. I authorize the use of my signature on all submissions. Dr Kristiansen may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Signature of Patient Date

_____
Print Name