Mark E. Einbecker, M.D.
Lisa T. DeGnore, M.D.

Paul J. Nicholls, M.D.
Mathew A. Nicholls, M.D.

All information is strictly confidential.

Patient Information

Name ____

Home phone _____________ cell phone ____________ work phone ___________

Address _______________________ city _____________ state ___ zip ________

Email ____

Do you currently reside in or on temporary leave from a nursing facility? ______

If so, please provide the nursing homes address and phone # below:

____

Birthdate _______ age ____ sex ___ marital status ____ SS# _______________

Employer ________________________ Employer phone _____________________

Worker's Compensation/Auto Information

Is your injury work/auto related? yes no Date of injury: ______________

If so has a claim been filed? yes no Place of accident/injury: ____________

Claim # ________________________ Contact name: ______________________

Contact phone number: _______________________________

Insurance Subscriber Information

Name ____

Home phone ____________ cell phone ______________ work phone ________

Address ______________________ city ______________ state ___ zip ________

Birthdate _________ SS # _______________ relationship to patient ___________

Insurance Information (must have card at registration)

Primary insurance __________________ policy # __________________________

Group # _________________________ address ____________________________

Other insurance ___________________ policy # ___________________________

Group # _________________________ address ____________________________

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Emergency contact (nearest relative friend not living with you)

Name ____________________ cell phone __________ home phone __________

Address _________________________________ relationship _______________

Consent for treatment

I, hereby give my permission for Drs. Einbecker, P. Nicholls, DeGnore, and M. Nicholls to render treatment to me/my dependent. I understand that I will be given all available pertinent information, prior to treatment being rendered. I understand that I may decline recommendation treatments at anytime, but that if I choose to do so, it is at my own medical risk.

Signed ________________________________ date ______________________

Consent to release/obtain medical information

Permission is, hereby, granted to Drs. Einbecker, P. Nicholls, DeGnore, and M. Nicholls to release information to my insurance company, employer, attorney, workers compensation carrier, physician/facility referred to for further treatment, and/or my referring family physician. Permission is hereby, granted to any facility where I have previously been treated to release medical records/x-rays to Drs. Einbecker, Nicholls, DeGnore, and M. Nicholls.

Signed ________________________________ date _______________________

Authorization for payment of benefits

I authorize insurance payment benefits to Drs. Einbecker, Nicholls, DeGnore, and M. Nicholls for service rendered. I understand that any charges not paid by my insurance company are my responsibility, and are due and payable by me.

Signed ________________________________ date _______________________

Medicare patients only

I authorize payment of Medicare benefits to Drs. Einbecker, Nicholls, DeGnore, and M. Nicholls for services rendered, and I authorize the release of medical information to Health Care Finance Administration (HCFA) and/or its agents. I have received the supplier standards information sheet.

Signed ________________________________ date _______________________