PLES L. KUJAWA, MD, PA

PATIENT REGISTRATION FORM

Please print legibly. All sections must be completed to satisfy the requirements necessary to treat and bill on your behalf. Please **complete all areas** so your treatment can be properly documented and represented. Thank you for your cooperation.

Reason for Today's Visit:____

PATIENT INFORMATION

First Name MI	Last Name	____ Single ____ Widowed ____ Married ____ Divorced
Street Address/Apt #	City, State. Zip	Telephone # Cell Phone #
Birth Date Gender M F	SS#	Email Address
Employer	Address, City, State, Zip	Work Phone #
Spouse's Name	Spouse's Employer	Employer Work #

RESPONSIBLE PARTY Please complete with Insured Parent Information for minors.

Name	Relationship to Patient	SS#
Street Address/Apt #	City, State. Zip	Telephone #
Employer	Address, Ste #, City, State. Zip	Telephone #

PRIMARY INSURANCE

Name of Insurance	Policy/ID/Certificate	Group #
Subscriber's First Name Last Name	DOB SS#	Relationship to Patient

SECONDARY INSURANCE: **Worker's Compensation/Auto Accident Patients** – Please list personal Insurance as Secondary

Name of Insurance	Certificate/Policy/ID	Group Number
Subscriber First Name Last	DOB SS#	Relationship to Patient

WORKER'S COMPENSATION/AUTO ACCIDENT: Patient is responsible regardless of insurance benefits or settlement

TWCC #/Auto Insurance Policy #	Company/Employer at Time of Accident	Date of Injury/Accident
Insurance Company Name	Phone #	Has Employer been notified of accident? Y/N Have you been treated for this injury? Y/N
Attorney Name		Phone #

FAMILY AND REFERRING PHYSICIAN INFORMATION

Referring Physician First Name Last Name	Complete Address Phone #
Family Physician First Name Last Name	Complete Address Phone #
Pharmacy Name	**Phone #**

ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR TREATMENT:

I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf. I understand that I am fully responsible for all charges incurred, regardless of my insurance status, for professional services rendered. This release is in effect for one year from date signed.

Signature:____ Date:_____________________________
Patient or Authorized Representative

MEDICARE PATIENTS ONLY

Name of Beneficiary:_______________________________________ HI Claim #:__________________________

I request that payment of authorized Medicare benefits be made on my behalf to Ples L. Kujawa, MD, PA for any services furnished to me by that physician. I authorize any holder of medical information, concerning me, to release this information to the Health Care Financing Administration and its agents. This information will be used to determine payable benefits.

I hereby authorize Medicare to furnish to the above-named doctor any information regarding my Medicare claims under Title XVII of the Social Security Act.

Signature:____ Date:_____________________________

We will continue to provide quality Healthcare to our patients. We will endeavor to accommodate patients' requests. However, due to Ples L. Kujawa, MD, PA being a surgical practice, patient emergencies and unforeseen situations are not uncommon and are beyond your doctor's control. It may be necessary to reschedule or delay your appointment time. We apologize for any inconvenience this may cause you.

MISSED APPOINTMENT POLICY: All appointments must be cancelled at least 24 hours prior to the scheduled appointment time or a **$35** fee will be charged; **$250** fee charged for missed procedures/surgeries.

FORMS: There is an additional charge to complete many forms (**DMV placard$20; State Disability $25, all other forms $20/page**). Payment is expected prior to form completion.

I have read and understand all the information on this form.

____
Patient Signature Date

Guardian/Representative____
Print Name Signature Date