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MARTINA KOLLER, MD ( )
W. BRUCE MILLIMAN, ND ( )
EVA MILLER, ND ( )
JANE PEMBERTON, MD ( )
FERNANDO VEGA, MD ( )

PATIENT REGISTRATION

Please fill out completely

First Name: MI: Last:

Street Address:

City: State: Zip:

Email: Gender: ( )M ( )F Home ph: ( )

Employer: Work ph: ( )

Date of Birth: - - Age: Alt ph: ( )

Employment: ( )Employed ( )F/T Student ( )P/T Student ( )Retired ( )Other

Marital Status: ( )Single ( )Married ( )Divorced ( )Widowed ( )Dependant ( )Partnered ( )Other

Responsible Party: Phone: ( )

Address: City, ST, ZIP:

In emergency contact: Phone: ( )

Referred By:

PRIMARY INSURANCE

Insurance Company Name: Phone: ( )

Claims Address: City, ST, ZIP:

Subscriber's Name: Date of Birth: - - SSN:

Relationship to you: ( )Self ( )Spouse ( )Dependant ( )Other

Subscribers Address: City, ST, ZIP:

I.D. # as shown on card: Group #:

Employer of insured: Phone: ( )

SECONDARY INSURANCE

Insurance Company Name: Phone: ( )

Claims Address: City, ST, ZIP:

Subscriber's Name: Date of Birth: - - SSN:

Relationship to you: ( )Self ( )Spouse ( )Dependant ( )Other

Subscribers Address: City, ST, ZIP:

I.D. # as shown on card: Group #:

Employer of insured: Phone: ( )

I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assesed a fee. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Signature Date