PATIENT REGISTRATION FORM

MJ HABER, MD, LLC
1140 Willagillespie Rd Suite 42 Eugene, OR 97401
Office: 541-800-8970

Clients Name: _____

Street Address: _____

City, State and Zip Code _____
(If your mailing address is a P O Box-Please list street address along with the P O Box)

Clients Phone #: Home _____ Cell _____ Work _____

Would you like appointment reminders by text? Yes or No

Marital Status/Partner Information: _____

Clients DOB: _____ O.D.L. #: _____

Nearest Friend or Relative not living with you in case of an emergency:

Name: _____

Address: _____

Home Phone #: _____ Cell #: _____ Work #: _____

RESPONSIBLE PARTY: (If different from above)

Name: _____
Address _____
Phone: Home _____ Cell _____ Work _____

INSURED INFORMATION: PRIMARY

Name: _____
Relationship to patient: Self _____ Spouse _____ Child_____ Other_____

Subscribers DOB: _____
ID #: _____ Group #: _____

Employer and Occupation: _____

Insurance Company: _____ Phone: _____

Send Claims to Address: _____
_____

INSURED INFORMATION: SECONDARY

Name: _____
Relationship to patient: Self _____ Spouse _____ Child_____ Other_____

Subscribers DOB: _____
ID #: _____ Group #: _____

Employer and Occupation: _____

Insurance Company: _____ Phone: _____

Send Claims to Address: _____

_____

ADDITIONAL INFORMATION:

By whom were you referred to this office? _____

Please list other health care providers that might be relevant to your treatment.
(This office will not contact these individuals unless you sign a release of information).

_____, _____, _____,

_____, _____, _____,

Please list any medication you are currently taking:

_____, _____, _____,

_____, _____, _____,

_____

_____

_____

What pharmacy would you like on file?_____

Financial Agreement:

I hereby give authorization for payment of insurance benefits to be made directly to **MJ Haber, MD, LLC**. I authorize this healthcare provider to release any information necessary to ensure payment by my insurance company. I understand I am financially responsible for all charges not covered by insurance, including patient co-pay, deductible, or non-covered services. Charges for paperwork are not covered by insurance and you will be charged a $25 fee. I understand that my account may be turned over to collections for failure to make full payment within 90 days upon receiving my statement.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to a reasonable attorney's fees and cost of collections.

I hereby assign all medical benefits to which I am entitled, including private insurance and all other health plans to **MJ Haber, MD, LLC.**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Signature of Patient or Legal Guardian Date

Acknowledgment of Notice of Privacy Practices:
The notice of Privacy Practices was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices. A copy is available to you upon request.

_____ _____

Signature of Patient or Legal Guardian Date
