Patient Registration

Patient's full legal name.....Date of birth.....

Patient's social security number.....Sex/gender.....

Home address , with town and zip code.....

Phone number(s).....Email.....

Emergency contact name.....Emergency contact phone.....

If patient is a child under 18,

Legal parent/guardian name:.....Date of birth.....

Home address , with town and zip code.....

Phone number(s).....Email.....

If someone other than you is responsible for the medical bills, fill in:

Name.....Date of birth.....Social security #.....

Home address , with town and zip code.....

Phone number(s).....Email.....

If you have insurance, fill in:

Primary insurance company name.....Phone number for claims.....

Member ID number.....Group number.....

Policyholder name.....Policyholder date of birth.....

Relationship of policyholder to patient (e.g., spouse, parent, self, etc.).....

Please initial the statements with which you agree, and sign at bottom:

_____ I hereby authorize Leigh Saint-Louis, M.D., to treat me or patient designated above, of whom I am a legal guardian.

_____ I authorize Leigh Saint-Louis, M.D., to release my medical information to my insurance company or third party payers or its agents for completion of insurance claims and determination of benefits.

_____ I assign payment directly to Leigh Saint-Louis, M.D., LLC, for all covered medical services provided.

_____ I am financially responsible for appropriate deductibles, copayments, and non-covered services as explained to me by my insurance carrier. If my account is turned over to an attorney due to delinquency or nonpayment, I will be responsible for all costs of collection including court costs and reasonable attorney fees.

_____ I certify that the above information is true and correct. A copy of this authorization is considered valid as original.

Signature.....Today's date.....