Patient Registration

Mark J. Diercks, M.D.

Patient Name: SSN:

Street Address: Date of Birth:

City/State: Zip:

Home Phone: Work Phone: Marital Status: S M W Sep D

Emergency Contact Name: Phone:

Referred By: Allergies:

Patient/Parent Employer Information

Employer Name: Occupation:

Street Address: City/State: Zip:

Insured Person (if Not Patient)

Name: Phone:

Street Address: City/Sate: Zip:

Insured Person Employer Information

Employer Name:

Street Address: City/Sate: Zip:

Insurance

Please allow us to make a copy of your insurance card or cards.

Primary Care Physician (PCP):

☐ **I hereby authorize the release of information generated by Mark J. Diercks, M.D. to be forwarded to my PCP.**

☐ **I do NOT consent to the release of information generated by Mark J. Diercks, M.D. to be forwarded to my PCP.**

Signature: Date:

Authorization to Release Information and Assignment of Benefits

- I authorize the release of any medical information necessary to process this claim.
- I permit a copy of authorization to be used in place of the original.
- I authorize the release of any information pertinent to my case to any insurance company, adjuster, caseworker or attorney involved in this case.
- I authorize Mark J. Diercks, M.D., to apply for benefits on my behalf for covered service. I request that payment from my insurance company be made directly to him.
- I certify that the information I have provided is correct.

Patient Signature: Date:

Consent to Treat

I do hereby acknowledge, agree and give my consent for diagnosis and treatment, as may be deemed necessary or desirable by Dr. Diercks.

Patient Signature: Date

Please Note: If you do not cancel your appointments within a 24-hour period, you will be charged at the rate of a normal office visit. Please help us serve you better by keeping your scheduled appointments.