New Patient Registration

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date_____ Patient Name _____

SSN_____ Birth date _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Other _____

Occupation _____ Work Phone _____

Who referred you to Dr. Welden? _____

Person to contact in case of an emergency _____ Phone _____

Spouse/Guarantor Information

Name _____ SSN _____ Birth Date _____

Address (if different from patient) _____ Cell Phone_____

Employer _____ Occupation _____ Work phone _____

Insurance Information

Name of Insured _____ Relationship to patient _____

Birth date _____ SSN_____ Insurance Company _____

ID#_____ Group#_____ Customer service#_____

Insurance Address _____ City _____ State _____

Authorization & Release

As a courtesy, we will initiate a claim to your insurance company on your behalf and we will be happy to assist you. However, please keep in mind that insurance is a method for patients to be reimbursed for fees they have paid for physicians' services. Your insurance coverage is a contract between you and your insurance company, not our office. Insurance companies reimburse at various amounts, based on each subscriber's individual contract. Having insurance is not a substitute for payment of your charges, and you are responsible for full payment of your account

_____ _____

Signature Date

I understand that I am financially responsible for charges not covered by my insurance company. I also authorize Stephen W. Welden, M.D., P.A. to release any information acquired, including the diagnosis and records in the course of my examination and/or treatment.

_____ _____

Signature Date