PATIENT REGISTRATION

Arthur M Kunath, MD ______
Joseph E. Temming, MD ______
Kerry D. Burte, MD ______
Liza R. Varghese, MD ______
C. Lee Colglazier, MD ______

PATIENT INFORMATION

Name________________________ Birthdate__________ SS#______________

Address________________________ City______________ State______ Zip________

County______________ Home Phone.______________ Work Phone______________

Sex: M __F__ Age______ Single______ Married______ Widowed______ Divorced______

Spouse's Name________________________ Spouse's SS#______________ Spouse's D.O.B.__________

Emergency Contact Name & Phone No. ________________________________

INSURANCE INFORMATION (IF YOU WANT YOUR INSURANCE SUBMITTED BY OUR OFFICE, PLEASE FILL OUT THIS ENTIRE SECTION)

	PRIMARY INSURANCE	SECONDARY INSURANCE
Name Insurance Co.	1) ______________	2) ______________
Address	1) ______________	2) ______________
	______________	______________
Group Number	1) ______________	2) ______________
Certificate Policy No.	1) ______________	2) ______________
Subscriber's Name	1) ______________	2)______________
Subscriber's D.O.B. & Sex	1) ______________	2) ______________
Subscriber's Employer	1) ______________	2) ______________
Patient Relationship	1) ____SELF ____SPOUSE ____CHILD	2) ____SELF ____SPOUSE ____CHILD

Referring Dr.________________________ Family Dr.________________________

(Please give the name of your doctor, not the name of the practice)

Address________________________ Address________________________

Phone No.________________________ Phone No.________________________

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

MEDICARE & KY. MEDICAL ASSISTANCE: I certify that the information given me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier's, any information needed for this or related Medicare or KMA claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician(s) or organization furnishing the services or authorize such physician(s) or organization to submit to Medicare or KMA for payment to me.

I request that payment under the medical insurance program be made to Kunath, Burte & Temming, M.D., P.S.C. on any bills for the services furnished by Kunath, Burte & Temming, M.D., P.S.C. during the next 12 month period.

ALL OTHER INSURANCE: I hereby authorize Kunath, Burte & Temming, M.D., P.S.C. to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physician(s) and authorize and direct my insurance carrier or it's intermediaries to issue payment check(s) directly to the physician(s) rendering the covered services for the next 12 month period. I authorize Kunath, Burte & Temming, M.D., P.S.C. to furnish complete information to my insurance carrier or it's intermediaries regarding services rendered.

I AM RESPONSIBLE FOR OBTAINING ANY REFERRALS REQUIRED BY MY INSURANCE COMPANY.

________________________ SIGNATURE ______________ DATE