Registration :

Drs Deutscher & Rottinghaus

Date	Account ID	Chart ID	Other ID	Internal Use

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #

Address	Home Phone Work Phone Cell Phone	How did you hear of us?
Address 2	Email:	
City / State / Zip Code	Employer Name & Address	Occupation
Emergency Contact / Phone	Pharmacy	Phone

Pref Language:	Race:	Ethnicity:	County:

Provider	Family Physician	Referring Physician

Medical Insurance	Name & Address	Policyholder	Relationship	Copay	Policy ID	Group ID
1						
2						
3						

Policyholders/Guarantors (Person to be billed, if different than patient)

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work Phone	Email:
City / State / Zip Code	Employer Name & Address		Occupation

2. Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work Phone	Email:
City / State / Zip Code	Employer Name & Address		Occupation

HIPAA Approved Contacts

1. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work Phone

2. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work Phone

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Drs. Deutscher & Rottinghaus, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service. Account balances 120 days or older will be charged a 10% finance charge.

I acknowledge the HIPPA & Practice's Notice of Privacy Practices have been made available for me to review. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date
X	

Drs Deutscher & Rottinghaus
1140 SW Fairlawn Rd
Topeka, KS 66604
Phone: 785-271-8181
Email:

Please attach all pertinent insurance ID cards for photocopying.