BRUCE E. WEST, M.D.

PROFESSIONAL CORPORATION

Patient Registration Form

Please call **(248) 352-8970** for assistance.

PATIENT INFORMATION

Legal Name: Last	First	Initial	Social Security #
Address			Drivers License #
City	State	Zip	Marital Status **M S D W**
Work Phone # Extension	Home Phone #		Cell Phone #
E-Mail Address (optional)			Date of Birth
Employer or School			Occupation
Employer or School Address			Primary Care Physician
How did you hear about us?			
Emergency Contact	Relationship		Contact #

Please provide your current insurance card(s) and driver's license so that a copy may be made for your file.

Authorization to pay Benefits to the Physician and Release of Information:

I hereby instruct and direct my Insurance Company to pay by check made out and mailed to Bruce E. West, M.D., P.C.. If my current policy prohibits direct payment to my doctor, then I hereby also instruct and direct you to make out the check payable to me and Bruce E. West, M.D., P.C. Send the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENFITS UNDER THIS POLICY. A photocopy of this assignment shall be considered as effective and valid as the original.

I authorize Bruce E. West, M.D., P.C. to release any medical information required during the course of examination and treatment and permit payment directly to them any benefits due for their services rendered.

I certify that the information above is true and correct to the best of my knowledge. I recognize and accept responsibility for services rendered regardless of insurance coverage. I understand that my payment is expected at the time of service. This includes, but is not limited to co-insurance, co-payment, deductible and non-covered services.

Policy Holder Signature ______________________________ Date ______________

Spouse Signature ______________________________ Date ______________

Medicare Authorization

I hereby authorize payment of Medicare benefits to be made directly to Bruce E. West, M.D., P.C., for any services rendered to me by providers employed by that corporation. I authorize any holder of medical or other information about me to release to Bruce E. West, M.D., P.C. and its agents any information needed for the purpose of determining these benefits. I understand that this authorization is in effect unto revoked, in writing, by me.

Beneficiary Signature ______________________________ Date ______________

Beneficiary Signature ______________________________ Date ______________

Lahser Medical Campus, 27177 Lahser, Suite 100, Southfield, MI 48034