CLIENT REGISTRATION FOR
CHRISTOPHER J. RIEGEL, M.D.

Please print clearly your response to all requested information.
If you have any questions, please ask, THANK YOU!

PATIENT INFORMATION

Name	Home Phone
Address	Office Phone
City State Zip	Date of Birth Age
Single Married Divorced Widowed	Social Security #
Employer	Occupation
Office address	City State Zip

SPOUSE/PARENT INFORMATION

Spouse/Parent Name	Office Phone
Home Address	City State Zip
Employer	Occupation
Address	City State Zip
Social Security #	Date of Birth Age

INSURANCE INFORMATION

Insurance Company	Phone
Address	City State Zip
Group Number	Policy or ID Number
Spouse/Parent Insurance	Phone
Address	City State Zip
Group Number	Policy or ID Number

CONTACT FOR EMERGENCIES	Relationship
Home Telephone	Office Telephone
REFERRED BY	Relationship Phone

Thereby assign all medical and/or surgical benefits, to include major medical benefit to which I am entitled including medicare, private insurance, PPO plans and all other health plans to Chris Riegel, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I further agree that if my account becomes delinquent I will be charged an additional fee of 1.5% per month plus any collection costs. I hereby authorize said assigner to release all information needed to secure the payment.

Signed _____ Date _____