Patient Registration for Avery Wood MD and John Hearst MD

10 Bank Street PO Box 726 North Bennington, Vermont 05257

Primary Doctor (Dr Wood or Dr Hearst): ______________________

Patient Information:

Name: ____ Date of Birth: ____________

Marital Status: ____________ Gender: _____________ Race: _____________ Language: ____________

Mailing Address: ____

Street Address (if different): ____

Home Phone: _______________ Cell Phone: _______________ Email Address: ______________________

How can we best contact you: Home phone? ____ Cell phone? ____ Email?____ US mail? ________

Name of Employer: _________________________________Work Phone: ___________________________

Address: ____

Job or Position: ____

Names of the People in Your Household: ____

Emergency Contact:

Name: _________________________ Relationship: __________ Home phone: ___________________

Cell Phone: _______________ Address: ____

Name of Guarantor (the person who is responsible for this account): _________________________________

Date of Birth: ____________ Relationship: ___________ Phone: ________________________

Address: ____

Primary Insurance: ________________________________ Certificate Number: _____________________

Group Number:__________________________________ Employer: ____________________________

Subscriber Name: ________________________________ Date of Birth: _________________________

Secondary Insurance: ______________________________ Certificate Number: _____________________

Group Number: _________________________________ Employer: ____________________________

Subscriber Name: ________________________________ Date of Birth: _________________________

Patient's Name: ______________________________ Date of Birth: ______________________

Parent's or Guardian's Name (if applicable): ____

Insurance Benefits Agreement

I request that payment of authorized benefits be made on my behalf directly to Avery Wood MD LLC for services furnished to me by that physician or her associates. I understand and agree that I am responsible for the balance of my accounts. I certify that the information I have provided is accurate to the best of my knowledge. I will notify this office of any changes.

Signature: ______________________________ Date: ___________________________

FOR MEDICARE BENIFICIARIES:
Medicare Beneficiary's Lifetime Payment Authorization
I request that payment of authorized Medicare benefits be made on my behalf to:
Avery Wood MD LLC, 10 Bank Street, North Bennington, Vermont,
for any services furnished to me by Dr. Avery Wood or Dr. John Hearst. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature: ________________________________ Date: ______________________

Medigap Authorization

I request that payment of authorized Medigap benefits be made on my behalf to:
Avery Wood MD LLC, 10 Bank Street, North Bennington, Vermont,
for any services furnished to me by Dr. Avery Wood or Dr John Hearst. I authorize any holder of medical information to release to the Medigap insurer I have indicated any information needed to determine these benefits payable for related services.

Signature: ________________________________ Date: _____________________