JASON H. FROST, D.O., F.A.C.O.S.

This form is a confidential document. Information within this document will not be released without your expressed written permission.

Patient's name: ______________________ Date: __________
Address: ______________________
City: ______________________ State: ________ Zip Code: __________
Phone: (H) ______________ (W) ______________ (C) ______________
S.S.# ______________ Date of Birth: ______________ Sex: M______ F______
Marital Status: M _____ S _____ D _____ W _____ Spouse's Name: ______________
Patient's Employer: ______________________ Occupation: ______________
Emergency Contact Name & Phone Excluding Spouse: ______________________

Appt Date / Time: ______________ Referring Dr. ______________

INSURANCE VERIFICATION

INSURANCE: ______________ INS. PHONE: ______________
ID #: ______________ GROUP #: ______________
INSURED NAME: ______________ S.S. # ______________
INSURED'S DATE OF BIRTH: ______________ RELATIONSHIP: ______________
INSURED'S EMPLOYER: ______________ OCCUPATION: ______________
REFERRAL REQUIRED: YES _____ NO _____ ARE WE PROVIDERS: YES _____ NO _____
EFF. DATE: ______________ O.V. CO-PAY: ______________ DEDUCTIBLE: ______________
IN-NETWORK CO-INS.: ______________ TOTAL OUT OF POCKET: ______________
AMOUNT MET: (D) ______________ (CO-INS) ______________ LIFETIME MAX: ______________
CLAIMS ADDRESS: ______________________
OUTPT. BENEFITS: PRE-CERT REQ'D: ______________ DEDUCTIBLE: ______________
CO-PAY TO FACILITY: ______________ AMOUNT MET: ______________ CO-INS: ______________
OUT OF NETWORK BENEFITS: YES ____ NO ____ DEDUCTIBLE: ______________ MET: ______________
OUT OF NETWORK CO-INSURANCE: ______________ OUT OF POCKET: ______________

MEDICARE ID #: ______________ SUPPLEMENT: ______________
MEDICAID CARD #: ______________ ID #: ______________
ELIGIBLE: YES _____ NO _____ AUDIT #: ______________
MEDIPASS: YES _____ NO _____ PCP: ______________
MEDIPASS AUTHORIZATION NUMBER: ______________________

NAME of persons that we can speak to regarding your medical condition: ______________________

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the information contained in my chart, on my registration form, is true and correct. I understand this information is necessary for the processing of my claims and to ensure proper medical care. I understand that Dr. Frost does not carry Malpractice Insurance and authorize him to treat me. I also authorize the release of any other information necessary to process this claim and payment of medical benefits to Dr. Frost by my insurance company for services provided. I agree that I am responsible for any charges which are not authorized by my insurance company or government agency.

Signature: ______________________ Today's Date: ______________