WinterPark HERNIA CENTER

Charles J. Koller, M.D., P.A.
Diplomate, American Board of Surgery
Courtney Thompson PA-C

PATIENT REGISTRATION

Today's Date: _____ Account #: _____

Patient's Legal Name: _____ Sex: F ☐ M ☐ Date of Birth: _____
Last First M

Social Security #: _____ Driver's License #: _____

Home Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

If patient is a minor: Mother's name: _____ Father's name: _____

Employer: _____ Address: _____
Street City State Zip

SPOUSE OR PARENT/GUARDIAN INFORMATION

Name: _____ Relationship: _____
Last First M

Social Security #: _____ Date of Birth: _____

Address if different from above: _____
Street City State Zip

REFERRING DOCTOR/PRIMARY DOCTOR INFORMATION

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

PRIMARY INSURANCE

Primary Insurance: _____ Phone: _____

Policy/ID #: _____ Group Number: _____

Name of Policy Holder: _____ Relationship: _____

Policy Holder SS #: _____ Policy Holder D.O.B.: _____

Policy Holder Employer: _____

SECONDARY INSURANCE

Secondary Insurance: _____ Phone Number: _____

Policy/ID #: _____ Group Number: _____

Name of Policy Holder: _____ Relationship: _____

Policy holder SS #: _____ Policy Holder D.O.B.: _____

EMERGENCY INFORMATION
Please list a friend or relative (not of the same address) to contact in case of any emergency

Name: _____ Relationship: _____
Last *First* *M*

Address: _____
Street *City* *State* *Zip*

Day time Phone: _____ Alternate Phone: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
I authorize **Charles J. Koller, M.D., P.A.** to release any medical information necessary to process health insurance claims.

_____ INITIALS

ASSIGNMENT OF HEALTH INSURANCE BENEFITS
I authorize payment of medical benefits applicable to services cited on the claim form to **Charles J. Koller, M.D., P.A.**

_____ INITIALS

CONSENT FOR TREATMENT
This consent is valid during the entire term of my association with **Charles J. Koller, M.D., P.A.** and may be relied upon unless, and until, revoked by patient or those acting for patient, in writing. Knowing that I am suffering from a condition requiring medical treatment, I do hereby voluntarily consent to such diagnostic procedures as are necessary in the judgment of the physician (s) in charge. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of examination or treatment in the hospital or office. If a biopsy is deemed necessary, I hereby authorize **Charles J. Koller, M.D., P.A.** to send a biopsy specimen to a suitable laboratory for a pathology report.

_____ INITIALS

GUARANTEE OF ACCOUNT
I hereby authorize **Charles J. Koller, M.D., P.A.** to provide such information as may be required by state or federal agencies or my insurance company, and for and in consideration of the services rendered to patient, we, the undersigned, jointly or severally, promise to pay the full amount of charges for such services, on demand, or by such future date as may be determined by **Charles J. Koller, M.D., P.A.** I understand that my bill will be due and payable in full on or before such date. In the event of default, I agree to pay a reasonable attorney fee and costs.

_____ INITIALS

Signature: _____ Date: _____

If this authorization is signed by an individual's personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____ Relationship: _____

Are you the patient's legal guardian? ☐ Yes ☐ No*

**If no, please notify the front desk receptionist.*