

*Dr. Gerald D. Ebner*  
**PATIENT REGISTRATION FORM**  
*Arbor Medical Group*

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

Patient's Full Name: \_\_\_\_\_  
(FIRST) (MIDDLE) (LAST)

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Patient's Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_ St: \_\_\_\_\_

Marital Status: S M D W Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
(STREET) (CITY) (ST) (ZIP)

Spouse or Parent's Name: \_\_\_\_\_ Hm#: \_\_\_\_\_ Wk#: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Who is the insurance policy holder?: Self Spouse Parent- Mother or Father

Name of Policy Holder: \_\_\_\_\_ Insurance Name: \_\_\_\_\_

Social Security # or Policy ID#: \_\_\_\_\_ Employer of Policy:  
\_\_\_\_\_

DOB: \_\_\_\_\_ Do you have a PRIMARY CARE PHYSICIAN appointed by your insurance?: Y or N

Emergency contact other than spouse: \_\_\_\_\_

Home #: \_\_\_\_\_ Work#: \_\_\_\_\_

My permission is granted to *Arbor Medical Group* to disclose medical information to other treating physicians regarding my care. I authorize the release of such records for the purpose of obtaining reimbursement from my insurance company. All medical/surgical benefits are assigned to *Arbor Medical Group* for billed services. I understand that I am financially responsible for charges related to medical and/or surgical services.

Patient's or Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_