JOHN A. LORAAS, PH.D, PA

7373 W. 147TH ST., STE. 166
APPLE VALLEY, MN 55124
(952) 432-3220 FAX (952) 891-4622

PATIENT REGISTRATION FORM

PATIENT'S NAME_____ AGE_____ DOB_____/_____/_____

ADDRESS_____
STREET *CITY* *ZIP*

SCHOOL (if student)_____ HOME PHONE ( ) _____

EMPLOYER _____ WORK or CELL PHONE ( ) _____

OCCUPATION_____ PREFERRED NUMBER FOR OFFICE TO CALL_____

NAME OF REFERRAL SOURCE:_____

IN CASE OF EMERGENCY CONTACT:_____ RELATIONSHIP:_____

HOME PHONE ( ) _____ WORK PHONE ( ) _____

FINANCIALLY RESPONSIBLE PARTY (Guarantor)
If Different Than Above

NAME_____ RELATIONSHIP TO PATIENT_____

ADDRESS_____ HOME PHONE ( ) _____
EMPLOYER_____WORK or CELL PHONE ( )_____

OCCUPATION_____

INSURANCE INFORMATION

INSURANCE COMPANY NAME, ADDRESS AND PHONE	POLICY # (ID #)	GROUP #	NAME OF POLICY HOLDER	POLICY HOLDER BIRTHDATE
PRIMARY	DEDUCTIBLE:	COPAY:		
SECONDARY	DEDUCTIBLE:	COPAY:		

I authorize JOHN A. LORAAS, PH.D., PA to release information regarding diagnosis, assessment and treatment to my insurance company for the purpose of supporting my need for care and for receiving the benefits due to me:

Signature_____ Date_____

I hereby authorize direct payment to JOHN A. LORAAS, PH.D., PA of any and all benefits for charges for examination and/or treatment received by me or my dependents:

Signature_____ Date_____