**BRUCE W. HALLMANN, M.D.**
*ORTHOPEDIC SURGEON*
5201 S. Willow Springs Road
LaGrange, Illinois 60525

**PATIENT REGISTRATION**

**Name:** _____ **Male** ☐ **Female** ☐

**Address:**_____ **City:**_____**State:**____**Zip:**_____

**Phone:** _____ **Cell Phone:**_____**Birth Date:** _____

**Email:** _____

**Social Security No:**_____**Workers' Comp Case:** **Yes** ☐ **No** ☐

**Insurance Carrier name:**_____

**If you are the SPOUSE or DEPENDENT of the primary cardholder, please provide their date of birth, (the insurance company will not process the claims without it and YOU COULD BE RESPONSIBLE FOR PAYMENT!)**

**SPOUSE Birth Date:** _____

**Patient's Employer:** _____ **Phone: (  )**_____

**Emergency Contact:** _____ **Phone: (  )** _____

**Primary/Referring Physician:**_____
**(**Medicare patients **MUST** complete this item. Medicare requires this information and will reject the claim without it! **YOU** may then be **RESPONSIBLE** for payment of the charges).

I authorize **RELEASE OF MY MEDICAL INFORMATION** to the following persons upon their request:

_____ _____
**Name of Individual – Relationship to patient** **Name of Individual – Relationship to patient**

I authorize release of information necessary to procure insurance information for billing services rendered.
I authorize direct payment to be made to Bruce W. Hallmann, M.D.

This authorization is effective unless revoked or terminated by me (the patient) or by the patient's personal representative. I have the right to revoke this authorization by submitting it in writing to: Bruce W. Hallmann, M.D. S.C.

I understand I am fully responsible for payment of all charges, even if they are deemed non-reimbursable or unnecessary by **MEDICARE OR PRIVATE** insurance.

**Payments (such as co-payments, deductibles, etc.) are payable when service is rendered**, unless other arrangements are made prior to treatment. Please present valid insurance card at time of registration.

If patient is a minor (under 18 years of age), parent or guardian signature is required.

_____ _____
**Signature of Patient, Parent or Guardian** **Date**