WINTER PARK SURGICAL ASSOCIATES

General, Laparoscopic & Robotic Surgery

Charles J Koller MD FACS
Diplomate, American Board of Surgery

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*

Daytime 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

Charles J. Koller, MD, PA *is the parent corporation for Winter Park Hernia Center.*

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.*