REGISTRATION (Please Print)

Dr. Barry Richter
Cayman Clinic, 439 Crewe Road, George Town, Grand Cayman

Date____/______/______
Day Month Year

PATIENT INFORMATION

Patient Name: ____________________ __________________ ___ ______________________
last first ini name you prefer to be called

Mailing Address: PO Box:______________City______________________________

Country____Zip Code______

Home phone: _______________Cell: _________________Birth date_____/_____/______Age_____
Day Month Year

e-mail: ___________

Marital status: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient's Employer _______________________Patient's Occupation____________________________

Work Phone _________Business address ____

In case of emergency who should be notified? __________________ Phone ______________________

Whom may we thank for referring you? _____________________________

PRIMARY INSURANCE

Primary Insured Person: ___________________________ ___________________ _________
last first ini

Relation to Patient _____________ Birth date _____/_______/______ Phone ____________
Day Month Year

Mailing Address (if different from patient's) __________________ _______________ ____________
PO Box city state/province

Insured's Employer _______________________ Occupation _________________________

Business address___________________________________ Business Phone _____________________

Insurance Company___________________________ Contract # ________________________________

Group # ___________________________________ ID # ___________________________________

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐Yes ☐No
Subscriber Name: _________________________________ _________________________ _________
last first ini

Relation to Patient _____________ Birth date _____/_______/______ Phone ___________
Day Month Year

Insurance Company_________________ Contract # ___________ Group # __________ID # __________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with____________________
name of insurance company(ies)
____________________ and assign directly to Dr. B.W. Richter all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X__________________________________ ________________________ ________________________
Responsible Party Signature Relationship Date