Dr. Rolf Maijer, Inc.
Sleep, Pain and Fatigue Management

ADULT PATIENT REGISTRATION

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI

☐ MALE ☐ FEMALE	BIRTHDATE *mm/dd/yyyy*	AGE

STREET ADDRESS	CITY	PROV	POSTAL CODE

CELL PHONE	HOME PHONE	OTHER PHONE

EMAIL	SPOUSE / PARTNER'S NAME

PREFERRED CONTACT	SEND APPOINTMENT REMINDERS BY
☐ CELL ☐ HOME ☐ OTHER	☐ TEXT ☐ EMAIL ☐ BOTH

EMERGENCY CONTACT INFORMATION

NAME	HOME PHONE
RELATIONSHIP TO PATIENT	CELL PHONE

HEALTH CARE PROVIDERS

PRIMARY PHYSICIAN	PHYSICIAN'S PHONE	PHYSICIAN'S FAX
PRIMARY DENTIST	DENTIST'S PHONE	DENTIST'S FAX

SPECIALISTS *Please list doctors that you see regularly*

WHO MAY WE THANK FOR THE REFERRAL?

BILLING INFORMATION

ADDRESS *If different than above*	CITY	PROV	POSTAL CODE

PREFERRED METHOD OF PAYMENT
☐ CHEQUE ☐ E-TRANSFER (INTERAC) ☐ DEBIT CARD ☐ CREDIT CARD

WOULD YOU LIKE ASSISTANCE WITH COMPLETING INSURANCE PAPERWORK?	INSURANCE COMPANY
☐ YES ☐ NO	

FINANCIAL POLICY: I understand that payment in full is expected at the time of service. Dr Maijer's office will provide necessary documentation to assist with claim submission and reimbursement from Insurance Companies.

CONSENT TO TREATMENT: I grant Dr Rolf Maijer, Inc. to administer treatment and perform procedures as deemed necessary.

RELEASE OF INFORMATION: I authorize the release of medical information to the following individuals *(please check)*

- ☐ Insurer, or the insurer's agents, to process my payments for service.
- ☐ Dentist: ____
- ☐ Primary physician: ____________________________________
- ☐ Other physicians: ____________________________________

To the best of my knowledge, all of the information above is true and correct.

PATIENT SIGNATURE	NAME PRINTED	DATE