



Patient Registration

Ki Hassler D.O., F.A.C.C.
1215 Jacaranda Blvd
Venice, FL 34292
Phone: 941-451-8282
Fax: 877-652-3059

Full Name _____

SSN _____ - _____ - _____ DOB _____ Sex _____

Race/Ethnicity _____ Marital Status _____

Florida Street Address _____

City _____ Zip code _____

Out of State Address _____

City _____ State _____ Zip code _____

Email _____

Home Phone _____ Work Phone _____

Mobile Phone _____ Preferred Phone: H W M

Primary Care Physician _____

Consent to Policies

We accept Medicare Assignment and participate in some Commercial Insurance Programs. All Deductibles and Co-pays are due at the time of service. We bill your insurance as a courtesy. We accept cash, checks, American Express, Visa, Mastercard, and Discover. There is a \$25.00 service fee for returned checks.

I HAVE READ

- THE ABOVE STATEMENT
- OFFICE POLICIES
- PRIVACY POLICIES

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED.

SIGNATURE _____ DATE _____