ACCOUNT # _____

PATIENT REGISTRATION FORM

NAME: _____
First Middle Last

ADDRESS: _____
Street Address Apt. No.

_____
City State Zip

HOME PHONE: ( ) _____ CELL PHONE: ( ) _____

WORK PHONE: ( ) _____ **PREFERRED PHONE (circle one): CELL / HOME / WORK**

E-MAIL ADDRESS: _____

BIRTHDATE: _____/_____/_____ SEX: Male _____ Female _____
Month Day Year

MARITAL STATUS: (circle one) S M D W S.S.#: _____

EMPLOYER/SCHOOL: _____ OCCUPATION: _____

EMERGENCY CONTACT: _____ EMERG. PHONE: ( ) _____

REFERRING PHYSICIAN / PHONE NUMBER: _____

PRIMARY INSURANCE COMPANY: _____

SECONDARY INSURANCE COMPANY: _____

PRIMARY POLICY HOLDER INFORMATION:

NAME: _____ HOME PHONE: ( ) _____

EMPLOYER: _____ WORK PHONE: ( ) _____

DATE OF BIRTH: (required) _____ RELATIONSHIP TO PATIENT: _____

PLEASE CHECK HERE IF YOU HAVE NO INSURANCE: _____

I CERTIFY THAT I AM RESPONSIBLE FOR PAYMENT FOR PROFESSIONAL SERVICES RENDERED.

PATIENT SIGNATURE _____

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION

I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance.

I also authorize the release of any information to the referring physician and/or my insurance provider in order to process my claims.

Signed _____
(Patient) (Date)