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Patient Registration Form

⚠ *FULL COMPLETION OF THIS FORM IS REQUIRED* ⚠

Please Print

Patient Information

Patient Name_____ (LAST), _____ (FIRST), _____ (M.I.) Sex: ☐ Male ☐ Female

Date of Birth: _____ (MONTH) /_____ (DAY) /_____ (YEAR) ☐ Single ☐ Married ☐ Wid ☐ Sep ☐ Div

Home Address: _____ City: _____ State: _____ Zip: _____

Home: (_____) _____-_____ Work: (_____) _____-_____ Cell: (_____) _____-_____

Indicate Number Priority (1,2,3): __ home __ work __ cell Email: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: (_____) _____-_____

Purpose of Visit: _____

Insurance Information

Required in order to file claims

Name of Insurance: _____

Address: _____ Phone: (_____) _____-_____

ID No. _____ Group No. _____ Effective Date _____ (MONTH) /_____ (DAY) /_____ (YEAR)

Subscriber (If different from patient): _____ Sex: ☐ Male ☐ Female

Date of Birth: _____/_____/_____ Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian

Employer: _____ Occupation: _____

Party Responsible for this Account (if different from subscriber): _____

Home: (_____) _____-_____ Work: (_____) _____-_____ Cell: (_____) _____-_____

Primary Care Physician: _____ Phone: (_____) _____-_____

Address: _____ City: _____ State: _____ Zip: _____

Whom may we thank for your referral: _____

Assignment of Benefits

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to this physician for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original. If I do not provide your office with a referral when required, I will be responsible for the payment. **I understand and agree that I am financially responsible for charges not paid by my insurance company and that payment is due at the time of service.**

_____

Signature of Patient, Insured, or Beneficiary
or Parent/Guardian (if patient is minor)

_____ (MONTH) /_____ (DAY) /_____ (YEAR)

Today's Date

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