PATIENT REGISTRATION-PLEASE PRINT ALL INFORMATION
ALL UNDERLINED INFORMATION IS REQUIRED TO BE COMPLETED

Mr. Mrs. Ms. Dr. Other_____________

PATIENT NAME: First:_________________________MI:_____Last:______________________________

HOME ADDRESS: ___________________________________ Home Phone: ( )___________________

____ Work Phone: ( )___________________

City/State/Zip: ______________________________________ Social Security #:______________________

Cell Phone: ( )___________________ Email: _________________ Date of Birth:__________________

Marital Status: Sex: M F

Single Married Separated Divorced Widowed

Spouse's Name: _____________________________________ *Spouse's* Employer: __________________

(If minor child, please list parent's or guardian's names) (If minor, please list parent or guardian's employer)

Spouse's Address:____________________________________ Employer's Address: __________________

_____________________________________ ______________________

Patient's Employer: __________________________________ Emergency Phone Number: ______________

Employer's Address: _________________________________ (Name & address of nearest relative not living with you)

___________________________________ __________________________________

___________________________________ __________________________________

Referred by: ____

(Please write the name of the person who referred you to this practice)

INSURANCE INFORMATION

Primary Insurance: ___________________________ Secondary Insurance: ________________________

Policy #: ___________________________________ Policy #: ___________________________________

Group #: ___________________________________ Group #: ___________________________________

Insured Name: ______________________________ Insured Name: ____________________________

(Please print name exactly as it appears on the card) (Please print name exactly as it appears on the card)

The receptionist will need to make copies of your insurance cards.

AUTHORIZATION

You will need to sign your name in all three places in order to process your insurance claim and see a physician with this practice.

_ I authorize the release of my medical information necessary to process this claim.

SIGNATURE of Patient or Legal Guardian: _________________________________

Date signed: __________________________

_ I authorize the release of payment for medical benefits to my physician.

SIGNATURE of Patient or Legal Guardian: _________________________________

Date signed: __________________________

_ I understand that I am ultimately financially responsible for all charges incurred for services rendered to me (or my child or person for which I am legally responsible to authorize medical treatment) which are not covered by my insurance plan for any reason, or for which I requested service without the appropriate insurance referral(s), or if my insurance coverage is no longer in effect.

SIGNATURE of Patient or Legal Guardian: _________________________________

Date signed:__________________________

Revised 11/2006