PATIENT REGISTRATION

DATE _____ FOR INTERNAL USE ONLY PATIENT NUMBER _____

PATIENT INFORMATION

SOCIAL SECURITY # _____ HOME ADDRESS _____

FIRST NAME _____ MIDDLE _____

LAST NAME _____ CITY _____ STATE ____ ZIP _____

SEX _____ DATE OF BIRTH _____ EMAIL _____

MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

HOME PHONE (____) _____

WORK PHONE (____) _____

(CHECK ONE)
☐ EMPLOYED ☐ RETIRED

CELL # (____) _____

☐ FULLTIME STUDENT ☐ OTHER

REFERRING PHYSICIAN _____

EMPLOYER _____ HOW DID YOU HEAR OF US? _____

PRIMARY INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURED / CARD HOLDER'S NAME _____

RELATIONSHIP _____ DOB _____ SOC. SEC. # _____

SECONDARY INSURANCE INFORMATION

INSURED / CARD HOLDER'S NAME _____

RELATIONSHIP _____ DOB _____ SOC. SEC. # _____

EMERGENCY CONTACT

RELATIONSHIP _____ SEX _____

FIRST NAME _____ MIDDLE _____ HOME PHONE (____) _____

LAST NAME _____ WORK PHONE (____) _____

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY # _____ SEX _____ DATE OF BIRTH _____

RELATIONSHIP _____ DAYTIME PHONE (____) _____

FIRST NAME _____ MIDDLE _____ EMPLOYER _____

LAST NAME _____ ADDRESS _____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

CITY _____ STATE ____ ZIP _____

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

_____ _____

SIGNATURE (Patient or Parent If Minor) DATE