

PATIENT REGISTRATION

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

DATE _____

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
 FULL TIME STUDENT OTHER
CELL PHONE (_____) _____
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 _____