REGISTRATION FORM

Date_____ Home Phone (____)_____ Cell Phone (___)_____

PATIENT INFORMATION

Name_____ SS# _____
Last Name First Name Middle Initial

Address_____ E-mail _____

City _____ State _____ Zip _____

Sex _____ M _____ F Age _____ Birthdate _____

Married_____ Widowed_____ Single_____ Minor_____ Separated_____ Divorced_____ Partnered for___ years_____

Patient Employer_____ Occupation _____

Employer Address _____ Employer Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ (_____)_____
Name Phone Number

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec.# _____

Address (If different from Patient's)_____ Phone (____) _____

City _____ State _____ Zip _____

Insurance Company _____

Subscriber # _____ Group # _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ___ Yes _____ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Insurance Company _____

Subscriber # _____ Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient