

PATIENT REGISTRATION

PATIENTS INFORMATION

LAST NAME _____ FIRST _____ MI _____
ADDRESS _____ CITY _____ STATE _____
ZIP CODE _____ HOME PHONE _____
WORK PHONE _____ CELL PHONE _____
SS# _____ - _____ - _____ DATE OF BIRTH ____/____/____
DRIVERS LICENSE # _____ WHOM DO YOU BANK WITH _____
PREVIOUS ADDRESS IF LESS THAN 2 YRS AT CURRENT ADDRESS _____

EMPLOYERS NAME _____
ADDRESS _____
CITY, STATE, ZIP _____
HOW WERE YOU REFERRED TO US? _____

SPOUSE'S INFORMATION

NAME _____ SS# _____ - _____ - _____
DATE OF BIRTH ____/____/____
EMPLOYER NAME _____
EMPLOYER ADDRESS _____
EMPLOYER PHONE # _____

EMERGENCY CONTACT-NOT LIVING WITH YOU

NAME _____ PHONE # _____
RELATIONSHIP _____

INSURANCES INFORMATION

PRIMARY INSURANCE

NAME OF COMPANY _____ MEMBER #/ID# _____
POLICY HOLDERS NAME _____

SECONDARY INSURANCE

NAME OF COMPANY _____ MEMBER#/ID# _____
POLICY HOLDERS NAME _____

AUTHORIZATION AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents behalf.

SIGNATURE OF PATIENT/PARENT OF MINOR

DATE