

DATE _____

PATIENT REGISTRATION

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

PATIENT INFORMATION

SOCIAL SECURITY # _____ HOME ADDRESS _____

FIRST NAME _____ MIDDLE _____

LAST NAME _____

SEX _____ DATE OF BIRTH _____

MARITAL STATUS MARRIED SINGLE
 DIVORCED WIDOWED

(CHECK ONE)
 EMPLOYED RETIRED
 FULLTIME STUDENT OTHER

EMPLOYER _____

CITY _____ STATE ____ ZIP _____

EMAIL _____

HOME PHONE (____) _____

WORK PHONE (____) _____

REFERRING PHYSICIAN _____

HOW DID YOU HEAR OF US? *Cell #* _____

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