

DATE _____

PATIENT REGISTRATION

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

HOME PHONE (____) _____

DIVORCED WIDOWED

WORK PHONE (____) _____

(CHECK ONE) EMPLOYED RETIRED FULL TIME STUDENT

REFERRING PHYSICIAN _____

OTHER _____

EMPLOYER _____

HOW DID YOU HEAR OF US? _____

INSURANCE INFORMATION (PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Commercial Medicaid Medicare Worker's Compensation Other _____

INSURANCE COMPANY _____

INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP _____

POLICY # _____ GROUP # _____ PHONE (____) _____

SECONDARY INSURANCE INFORMATION

Commercial Medicaid Medicare Worker's Compensation Other _____

INSURANCE COMPANY _____

INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP _____

POLICY # _____ GROUP # _____ PHONE (____) _____

WORKERS' COMPENSATION INFORMATION

COMPANY NAME _____

COMPANY PHONE (____) _____

SUPERVISOR'S NAME _____

SUPERVISOR'S PHONE (____) _____

EMERGENCY CONTACT

SOCIAL SECURITY # _____

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 PAY BENEFITS TO PHYSICIAN: I hereby 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

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

 SIGNATURE

 DATE