Patient Registration

PLEASE PRINT

Last Name:
First Name:
Middle Name:
Sex: Date of Birth:
Social Security No.:
Address:
Zip:
City: State:

Home Phone:
Work Phone:
Mobile Phone: ( ) _____ - _____
Marital Status:_____

Emergency Contact Information

Name:
Phone:

Employer Information

Name:
Phone:

Guarantor Information (to whom statements are sent)

Name:
Address:

Phone: ( ) _____ - _____

Other:

Patient Referred by:_____
Patient PCP:_____

Primary Insurance Information

Insurance Plan Name: ***SELF PAY***
Insurance Phone Number: ( )_____-_____

Address to Send Claims:
,

Policy Information

Patient's relationship to policy holder:_____
ID/Certification No.:
Policy/Group No.:
Issue Date: _____
Exp Date:_____
Copay Amount:_____
Co-insurance Percent:_____

Policy Holder

Last Name:
First Name:
Middle Name:
Address:
City: _____ State: Zip:
Social Sec Number: _____-_____-_____
Date of Birth: _____/_____/_____ Sex: **M** or **F**
Employer:_____

Secondary Insurance Information

Insurance Plan Name:
Insurance Phone Number: ( )_____-_____

Address to Send Claims:
,

Policy Information

Patient's relationship to policy holder:_____
ID/Certification No.:
Policy/Group No.:
Issue Date: _____
Exp Date:_____
Copay Amount:_____
Co-insurance Percent:_____

Policy Holder

Last Name:
First Name:
Middle Name:
Address:
City: _____ State: Zip:
Social Sec Number: _____-_____-_____
Date of Birth: _____/_____/_____ Sex: **M** or **F**
Employer:_____

ASSIGNMENT AND RELEASE:

- **I hereby assign my insurance benefits to be paid directly to the physician.**
- **I understand that I am financially responsible for all non-covered services.**
- **I authorize the physician to release any information required to process this claim.**

Signed_____ **Date:**_____