PATIENT REGISTRATION AND UPDATE

NAME:_____ **DATE OF BIRTH:**_____ **AGE:**_____
Last First MI

ADDRESS:_____
STREET CITY STATE ZIP

MAILING ADDRESS IF DIFFERENT:_____

HOME #:_____ **CELL #:**_____ **SSN:**_____

EMPLOYER:_____ **WORK #:**_____ **EXT:**_____

EMPLOYER'S ADDRESS:_____
STREET CITY STATE ZIP

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SPOUSE/GUARANTOR'S FULL NAME:_____ **DATE OF BIRTH:**_____ **SSN:**_____

SPOUSE/GUARANTOR'S EMPLOYER:_____ **SPOUSE/GUARANTOR'S WK #:**_____

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FAMILY PHYSICIAN/INTERNIST:_____ **REFERRED BY:**_____

EMERGENCY CONTACT PERSON AND PHONE NUMBER:_____

****

PRIMARY INSURANCE:_____**POLICYHOLDER:**_____ **ID #:**_____

SECONDARY INSURANCE:_____ **POLICYHOLDER:**_____ **ID #:**_____

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I authorize physicians and staff to communicate and/or leave messages for me at the following locations. Please circle where your messages may be left.

	(CIRCLE YES OR NO)	
HOME #:_____	**YES**	**NO**
WORK #:_____	**YES**	**NO**
CELL #:_____	**YES**	**NO**

Persons authorized to receive information about my healthcare:

Name:_____ **Relationship:**_____ **Phone #:**_____

Name:_____ **Relationship:**_____ **Phone #:**_____

I acknowledge that this authorization can only be rescinded by my written authorization.

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PLEASE CHECK HOW YOU WILL PAY FOR TODAY'S VISIT

___VISA **___PERSONAL CHECK** **___DEBIT CARD**
___ MASTERCARD **___CASH**

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FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT: I authorize treatment of the person named above and agree to all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. It is agreed that payments will not be delayed or withheld because insurance coverage or the pendancy of claims thereon and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original).

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of information to my insurance company, third party participants or others involved in processing the collection of this claim.

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SIGNATURE:_____ **DATE:**_____

If under 18 years of age SIGNATURE OF PARENT/GUARDIAN:_____ **DATE:**_____

Rev. 08/2007