

Patient Registration Form (Please use black ink only to complete form)

NAME _____ AGE _____ REFERRED BY: _____
 PATIENT CHART # _____ BIRTHDATE _____ SOCIAL SECURITY _____
 HOME PH # () _____ WORK PH # () _____ E-MAIL (OPTIONAL) _____
 MOBILE PH# () _____ FAX _____ MARITAL STATUS S M W D
 STREET ADDRESS (HOME) _____ APT _____
 CITY _____ STATE _____ ZIP _____
 DRIVER'S LICENSE# _____ STATE _____
 EMPLOYER/SCHOOL _____ TITLE _____
 STREET ADDRESS (WORK) _____ CITY _____ STATE _____ ZIP _____
 SPOUSE _____ AGE _____ BIRTHDATE _____
 SPOUSE EMPLOYER _____ TITLE _____ PHONE# () _____
 STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____
 PRIMARY LANGUAGE SPOKEN _____ RELIGION _____
 PRIMARY CARE DOCTOR _____ PRIMARY CARE DOC. PH# _____ FAX _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME _____ PHONE() _____ RELATIONSHIP _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

FATHER'S NAME _____ MOTHER'S NAME _____
 EMPLOYED BY _____ EMPLOYED BY _____
 POSITION _____ POSITION _____
 PHONE _____ PHONE _____

PRIMARY INSURANCE INFORMATION

INSURANCE CO. _____
 ADDRESS _____
 CITY/STATE/ZIP _____
 PHONE# _____
 ID# _____
 GROUP NAME OR # _____
 INSURED'S FULL NAME _____
 IS THIS AN EMPLOYER PLAN? _____
 INSURED'S SOCIAL SEC# _____
 INSURED'S DOB _____
 RELATIONSHIP TO INSURED _____
 (SELF---HUSBAND---WIFE---CHILD---OTHER)

SECONDARY INSURANCE INFORMATION

INSURANCE CO. _____
 ADDRESS _____
 CITY/STATE/ZIP _____
 PHONE# _____
 ID# _____
 GROUP NAME OR # _____
 INSURED'S FULL NAME _____
 IS THIS AN EMPLOYER PLAN? _____
 INSURED'S SOCIAL SECURITY# _____
 INSURED'S DOB _____
 RELATIONSHIP TO INSURED _____
 (SELF--HUSBAND-WIFE--CHILD--OTHER)

GURANTEE OF PAYMENT

I fully understand that I am directly responsible for payment to the Physician in this office for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay all collection costs including reasonable attorney's fees and costs in the event it becomes necessary to file suit to effect payment. I authorize payments to be made directly to my doctor.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Physicians in this office to release any information required in the course of my examination or treatment to my insurance company for the purpose of processing any insurance c claims.

ASSIGNMENT OF BENEFITS

If insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any benefits to the Physicians in this office for medical or surgical treatment received by me. In this circumstance, I understand that I am financially responsible for any charges not covered by insurance. I permit a copy of the authorization be used in place of the original.

Signature _____ Date _____

(Parent if minor)