PLEASE PRINT CLEARLY	New Patient Re	gistration	☐ Patient In	formation Update
Legal Name:First	Middle Initial	Last		
Date of Birth:/ Sex:			Professed La	nguaga
Street Address:				nguage.
City:				
			-	
Tele #: Home:				
Marital Status: S M W Sep D Race	*	Ethnicity: H	ispanic/Latino	Not Hispanic/Latino
Email Address:		Spouse's Na	me:	
Emergency Contact:	Tele	e #:		_ Relationship:
Patient Employer Information:				***************************************
Name:	Tele #:		Occu	pation:
Street Address:		City:		State: Zip:
Insured Person (if NOT patient):				
Name:			Date o	of Birth: / /
Email Address:				
Relationship to patient: Spouse _				
Information and Assignment of	Renefits:			
 I authorize the release of medical info I hereby authorize this organization to from my insurance company be made I certify the information I have report 	ormation necessary to property of apply for benefits on not directly to Haller & Huged with regard to my installed.	ny behalf for covere g P.C. (or to the part surance coverage is	d services rendere y who accepts ass correct.	authorization to be used in place of the original. ed by him/her or by his/her order. I request payment signment). evoked by either me or my insurance company at any
Date: Signature:				
Detient Course		(Patient, Parent	or Guardian)	
 Obtain payment from third-party payer Conduct normal health care operation I have been informed by you of your Notice of Priviple been given the right to review such Notice of Priviple 	to: It and follow-up among ers. Is such as quality assessivacy Practices containing ersy Practices prior to signature.	multiple health card ments and physicial ng a more complete gning this consent.	e providers who make the providers who make the providers which the providers who make the providers which the prov	s regarding my protected health information. I have be involved in the treatment directly or indirectly. The uses and disclosures of my health information. I have this organization has the right to change its Notice of the sees below to obtain a current copy of the Notice of
I understand I may request in writing you restrict understand you are not required to agree to my r	how my private informate equested restrictions, b	ation is used or disc out if you do agree t	losed to carry out han you are bound	treatment, payment or health care operations. I also d to abide by such restrictions.
I understand that I may revoke this consent in wr	iting at any time, except	to the extent that	you have taken ac	tion relying on this consent.
Patient Name:Please P	rint		Relationship to Pa	atient: Self Spouse Parent/Guardi