Patient Registration Form

PATIENT INFORMATION *(please print)*

First Name ______________ Middle Initial ______ Last Name ______________

Home Address ______________

City ______________ State ______________ Zip Code ______________

Billing Address (if different) ______________

Home Phone ______________ E-mail Address ______________

Work Phone ______________ Fax ______________ Cell Phone ______________ Pager ______________

Date of Birth ______________ Social Sec. # ______________ Sex ❑ M ❑ F

Driver's License Number: ______________ State Issued: ______________

Marital Status ❑ S ❑ M ❑ D ❑ W ❑ Other ______________

Ethnicity ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unknown/Not Reported

Race ❑ Asian ❑ Black ❑ Caucasian ❑ Multi-Racial ❑ Native American ❑ Pacific Islands ❑ Other ______________

Primary Language ______________ Secondary Language ______________

Referring Provider ______________ Primary Care Provider ______________

Employer ______________ Employer Phone ______________

Responsible Party Last Name (if applicable) ______________ First ______________ Initial ______

Emergency contact ______________ Relationship ______________ Phone ______________

Pharmacy ______________ Street Address ______________ City ______________

INSURANCE INFORMATION

Primary Insurance ______________

Policy Holder Name ______________ DOB ______________ SS# ______________

Address ______________ City, State, Zip ______________

Policy I.D. ______________ Group # ______________ Member # ______________

Co-pay Amount ______________ Policy Effective Dates: From: ______________ To: ______________

Patient Relation to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ ______________

Subscriber's Employer ______________

Secondary Insurance ______________

Policy Holder Name ______________ DOB ______________ SS# ______________

Address ______________ City, State, Zip ______________

Policy I.D. ______________ Group # ______________ Member # ______________

Policy Effective Dates: From: ______________ To: ______________

Patient Relation to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ ______________

BILLING INFORMATION

All professional services rendered are the responsibility of the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. If it is necessary to turn this service over to collection for non-payment after 90 days, then the patient is responsible for the bill, the interest, and collection and attorney fees.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER:
I hereby authorize payment directly to the undersigned Provider for my charges.

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize the undersigned Provider to release any information acquired in the course of my examination or treatment to my insurance company in writing or by fax.

Signature (Patient or Parent of Minor): ______________ Date: ______________

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