



PATIENT REGISTRATION

PERSONAL

Name (F) _____ (M) _____ (L) _____
 Sex M/F _____ Date of birth _____ Marital status Married Single Divorced Widowed
 Social Security Number _____ Driver's License # _____
 Primary Care Physician: _____ Phone # _____ Fax # _____

CONTACTS

Home Address _____ City _____ State _____ Zip _____
 Home Phone # _____ Work phone # _____ Cell phone # _____
 Emergency Contact _____ Relationship _____ Phone # _____
 Emergency Contact _____ Relationship _____ Phone # _____

EMPLOYMENT

Occupation _____ Employer Name _____
 Address _____ City _____ State _____ Zip _____
 Phone # _____ Fax# _____

INSURANCE

Primary Insurance Co _____ Phone # _____
 Id / Policy # _____ Group # _____
 Subscriber / Insured _____ Relationship _____ Sex _____
 Subscriber DOB _____ Social Security # _____ Driver's License # _____
 Subscriber Employer Name _____ Employer Phone # _____
 Secondary Insurance Co _____ Phone # _____
 Id / Policy # _____ Group # _____
 Subscriber / Insured _____ Relationship _____ Sex _____
 Subscriber DOB _____ Social Security # _____ Driver's License # _____
 Subscriber Employer Name _____ Employer Phone # _____

*** IMPORTANT INFORMATION ABOUT OUR OFFICE ***

All professional services rendered are charged to, and are the responsibility of, the patient, We will bill your insurance company(-ies) as a courtesy to you. You are responsible to provide our office with all applicable insurance cards. You are responsible for payment of your deductible and/or co-payments at the time services are rendered.

I authorize the release of any medical information necessary to process all claims. I authorize the release of payment for medical benefits to my physician. _____ (Initial)

I also understand that I am responsible for any unpaid balances, collection fees and/or attorney fees associated with the collection of any unpaid balances for services provided. Please sign below indicating the above information is accurate and complete to the best of your knowledge.

Signature _____ Date _____
 (Signature of parent or guardian authorizing treatment if the patient is a minor)

* Note: please notify us if any of the above information changes during the course of your treatment. **There is a fee for returned checks