Patient Registration Form

PATIENT INFORMATION *(please print)*

First Name _____ Middle Initial _____ Last Name _____

Home Address _____

City _____ State _____ Zip Code _____

Billing Address (if different) _____

Work 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 _____ How did you hear about us? _____

Referring Provider _____ Primary Care Provider _____

Employer _____ Employer Phone _____

Responsible Party Last Name (if applicable) _____ First _____ Initial _____

Emergency contact _____ Relationship _____ Phone _____

Preferred Pharmacy _____ Address _____ Tel. _____

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 ❑ _____

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.

Patient Signature _____