

PATIENT REGISTRATION

PATIENT

Last Name: _____ First Name: _____ Middle Int.: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Ph: _____ Cell Ph: _____ Email: _____

Date of Birth: _____ Sex: _____ Marital Status: _____

Language: _____ Ethnicity: _____ Race: _____

Is this visit related to an accident? Yes No

Were you referred to this practice? Yes No If yes, by whom? _____

Patient's Employer: _____ Phone: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Driver's License #: _____

Pharmacy of Choice (address and/or phone): _____

Emergency Contact Name: _____

Relationship: _____ **Phone:** _____

GUARANTOR

Responsible Party Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Responsible Party SS#: _____

Employer's Address: _____

INSURANCE INFORMATION

1 Primary Insurance Name: _____

Policy Holder's Last Name: _____ First Name: _____

Date of Birth.: _____ Relation.: _____

Certificate #: _____ Group #: _____

2 Secondary Insurance Name: _____

Policy Holder's Last Name: _____ First Name: _____

Date of Birth.: _____ Relation.: _____

Certificate #: _____ Group #: _____

Spouse's Name: _____ Work Phone: _____

Relative or Friend Not Living With You: _____ Phone: _____

SIGNATURE

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of the surgical and/or medical benefits. if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

AUTHORIZATION TO PAY RELEASE INFORMATION: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

Signature: (PATIENT OR PARENT IF MINOR)

SIGNATURE: _____ **DATE:** _____