Patient Registration Information

Please complete ALL sections below!

PATIENT'S PERSONAL INFORMATION

Marital Status: Single Married Divorced Widowed **Sex:** Male Female

Last Name ______ First Name ______ Initial ______

Address ______ Apt/Suite ______ City ______ State ______ Zip ______

Home Phone ______ Work Phone ______ Cell Phone ______

Date of Birth ______ Social Security Number ______

PATIENT 'S / RESPONSIBLE PARTY INFORMATION

Relationship to Patient: Self Spouse Child Other:______

Last Name ______ First Name ______ Initial ______

Address ______ Apt/Suite ______ City ______ State ______ Zip ______

Home Phone ______ Work Phone ______ Cell Phone ______

Date of Birth ______ Social Security Number ______

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist.

Primary Insurance Name ______ Phone ______

Address ______ Suite ______ City ______ State ______ Zip ______

Name of Insured ______ Date of Birth ______ Relationship to Insured Self Child Spouse Other

Policy # ______ Group # ______ CoPay ______

Secondary Insurance Name ______ Phone ______

Address ______ Suite ______ City ______ State ______ Zip ______

Name of Insured ______ Date of Birth ______ Relationship to Insured Self Child Spouse Other

Policy # ______ Group # ______ CoPay ______

PATIENT'S REFERRAL INFORMATION

Name ______

Address ______ Apt/Suite ______ City ______ State ______ Zip ______

Home Phone ______ Cell Phone ______ Fax ______

PHARMACY INFORMATION

Name ______

Address ______ Suite ______ City ______ State ______ Zip ______

Home Phone ______ Cell Phone ______ Fax ______

EMERGENCY CONTACT

Name ______ Relationship ______

Address ______ Apt/Suite ______ City ______ State ______ Zip ______

Home Phone ______ Work Phone ______ Cell Phone ______

Assignment of Benefits • Financial Agreement

I herby give lifetime authorization for payment of insurance benefits to be made directly to PRACTICE NAME, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I further agree that a photocopy of this agreement shall be as valid as the original.

Today's Date ______ Signature Field ______