

PATIENT REGISTRATION

First Name _____ Middle _____ Last _____

Home Address _____ Apt. # _____

City _____ State _____ Zip _____ Sex _____ Date of Birth _____

Phone(Home) _____ Cell _____ Work _____

Social Security # _____ Marital Status: S M W D

EMPLOYMENT: Student Retired Unemployed Self-Employed Employed

Employer _____ Occupation _____

Spouse's Name: _____ Phone # _____

Referred By: _____

INSURANCE INFORMATION / RESPONSIBLE PARTY

Primary
Insurance Company _____ Phone _____

Policy # _____ Group # _____ Specialist Copay _____

Card Holder's
First Name _____ Middle _____ Last _____

Date of Birth _____ Social Security # _____

Relationship to Patient Self Spouse Parent Sex _____

Employer _____ Phone: _____

Secondary Insurance Company _____

Phone _____ Policy # _____ Group # _____

Card Holder's
First Name _____ Middle _____ Last _____

Date of Birth _____ Social Security # _____

Relationship to Patient Self Spouse Parent Sex _____

Employer _____ Phone: _____

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.

Signature

Date

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

Signature

Date