Patient Registration

PLEASE PRINT

Last Name:

First Name:

Middle Name:

Sex: Date of Birth:

Social Security No.:

Address:

Zip:

City: State:

Home Phone:

Work Phone:

Mobile Phone: ( ) _____ - _____

Marital Status:

Emergency Contact Information

Name:

Phone:

Employer Information

Name:

Phone:

Guarantor Information (to whom statements are sent)

Name:

Address:

Phone: ( ) _____ - _____

Other:

Patient Referred by:_____

Patient PCP:_____

Primary Insurance Information

Insurance Plan Name:

Address to Send Claims:

Insurance Phone Number: ( )_____-_____

Policy Information

Patient's relationship to policy holder:_____

ID/Certification No.:

Policy/Group No.:

Issue Date: _____

Exp Date:_____

Copay Amount:_____

Co-insurance Percent:_____

Policy Holder

Last Name:

First Name:

Middle Name:

Address:

City: _____ State: Zip:

Social Sec Number: _____-_____-_____

Date of Birth: ____/____/____ Sex: **M** or **F**

Employer:_____

Secondary Insurance Information

Insurance Plan Name:

Address to Send Claims:

Insurance Phone Number: ( )_____-_____

Policy Information

Patient's relationship to policy holder:_____

ID/Certification No.:

Policy/Group No.:

Issue Date: _____

Exp Date:_____

Copay Amount:_____

Co-insurance Percent:_____

Policy Holder

Last Name:

First Name:

Middle Name:

Address:

City: _____ State: Zip:

Social Sec Number: _____-_____-_____

Date of Birth: ____/____/____ Sex: **M** or **F**

Employer:_____

ASSIGNMENT AND RELEASE:

- **I hereby assign my insurance benefits to be paid directly to the physician.**
- **I understand that I am financially responsible for all non-covered services.**
- **I authorize the physician to release any information required to process this claim.**

Signed_____ **Date:**_____