DATE _____

PATIENT REGISTRATION

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

PATIENT INFORMATION

SOCIAL SECURITY # _____

FIRST NAME _____ MIDDLE _____

LAST NAME _____

SEX _____ DATE OF BIRTH ____/____/____

MARITAL STATUS ☐ MARRIED ☐ SINGLE
☐ DIVORCED ☐ WIDOWED

(CHECK ONE) ☐ EMPLOYED ☐ RETIRED ☐ FULL TIME STUDENT

☐ OTHER _____

EMPLOYER _____

HOME ADDRESS _____

_____

CITY _____ STATE _____ ZIP _____

EMAIL _____

HOME PHONE (_____) _____

WORK PHONE (_____) _____

REFERRING PHYSICIAN _____

HOW DID YOU HEAR OF US? _____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____

INSURANCE COMPANY _____

INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP _____

POLICY # _____ GROUP # _____ PHONE (_____) _____

SECONDARY INSURANCE INFORMATION

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____

INSURANCE COMPANY _____

INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP _____

POLICY # _____ GROUP # _____ PHONE (_____) _____

WORKERS' COMPENSATION INFORMATION

COMPANY NAME _____ COMPANY PHONE (_____) _____

SUPERVISOR'S NAME _____ SUPERVISOR'S PHONE (_____) _____

EMERGENCY CONTACT

SOCIAL SECURITY # _____ SEX _____

FIRST NAME _____ MIDDLE _____ HOME PHONE (_____) _____

LAST NAME _____ WORK PHONE (_____) _____

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY # _____ SEX _____ DATE OF BIRTH ____/____/____

RELATIONSHIP _____ DAYTIME PHONE (_____) _____

FIRST NAME _____ MIDDLE _____ EMPLOYER _____

LAST NAME _____ ADDRESS _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CITY _____ STATE _____ ZIP _____

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 (Patient or Parent if Minor) 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