

PATIENT REGISTRATION FORM

PATIENT NAME: _____

DATE OF BIRTH: _____

AGE: _____ MALE _____ FEMALE _____

MARITAL STATUS: M _____ S _____ D _____ W _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK _____ CELL _____

SS# _____

REFERRING PHYSICIAN _____

IF PATIENT IS A MINOR: PARENT NAME: _____ PHONE # _____

INSURANCE INFORMATION:

Name of Insurance: _____ Subscriber Name _____

ID # _____ Subscriber D.O.B. _____

Group # _____ Subscriber SSN# _____

SECONDARY INSURANCE

Name of Insurance: _____ Subscriber Name _____

ID# _____ Subscriber D.O.B. _____

Group# _____ Subscriber SS# _____

WORKMANS COMP INFORMATION

EMPLOYER _____

ADDRESS _____

PHONE # _____

Insurance Name _____

Insurance Address _____

Claim # _____

EMERGENCY CONTACT

Name _____

Phone _____

Authorization to pay benefits to physician. I hereby authorize payments directly to the physician for his/her services as described, realizing I am responsible to pay any non covered services. I also realize I am responsible for any other costs incurred while collecting my outstanding balance(s).

Authorization to release information: I hereby authorize the physician to release any information required in the course of my treatment necessary to process insurance claims.

SIGNATURE: _____ DATE: _____