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_____PRIMARY PHYSICIAN_____
HAVE YOU HAD ANY RECENT LAB WORK?_____
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:_____