PATIENT REGISTRATION FORM

(Please Print Clearly)

PATIENT INFORMATION

Last Name ______________________

First Name ______________________ MI ______

Date of Birth ______________________

Sex ❑ M ❑ F

Child's relationship to responsible party: ______________________

Social Security No. ______________________

Birth Hospital ______________________

RESPONSIBLE PARTY INFORMATION (All information must be completed)

(Where the Patient Lives)

Last Name ______________________

First Name ______________________ MI ______

Address ______________________

City ______________________ State ______

Zip Code ______________________ Sex ❑ M ❑ F

Relationship to Patient ______________________

❑ Employed ❑ Full-time Student ❑ Part-time Student

Employer / School ______________________

Home Phone ( ) ______________________

Work Phone ( ) ______________________ Ext. ______

Cell Phone ( ) ______________________

Date of Birth ______________________

Social Sec. No. ______________________

Marital Status ❑ S ❑ M ❑ D ❑ W

Referred By ______________________

INSURANCE INFORMATION (Policy Holder)

(All information must be completed for billing purposes if insurance card is not available)

PRIMARY INSURANCE

Policyholder's Name ______________________ D.O.B. ______

Relationship to Patient ______________________

Insurance Name ______________________

S.S.# ______________________ Employer ______________________

Insurance Address ______________________

City ______________________ State ______ Zip Code ______

Insurance Phone ( ) ______________________

Group Name or No. ______________________

Insured's I.D. No. ______________________

Address of Policy Holder ______________________

SECONDARY INSURANCE

Policyholder's Name ______________________ D.O.B. ______

Relationship to Patient ______________________

Insurance Name ______________________

S.S.# ______________________ Employer ______________________

Insurance Address ______________________

City ______________________ State ______ Zip Code ______

Insurance Phone ( ) ______________________

Group Name or No. ______________________

Insured's I.D. No. ______________________

Address of Policy Holder ______________________

IN CASE RESPONSIBLE PARTY CANNOT BE REACHED, NOTIFY:

Relationship to Patient ______________________

Name ______________________

Address ______________________

State ______________________ Zip Code ______

Home Phone ( ) ______________________

Work Phone ( ) ______________________ Ext. ______

Cell Phone ( ) ______________________

AUTHORIZATION:

I hereby consent to any necessary medical treatment for myself or the minor named above for whom I am legally responsible.

ASSIGNMENT:

I permit payment directly to Drs. office for any benefits due for services rendered. I understand that I am responsible for all charges, whether or not covered by my insurance company.

MEDICAL RECORDS:

Authorization is hereby granted for release of any information required to process insurance claims. A copy of this authorization is as valid as the original.

Regardless of any claim pending, you will receive periodic statements if your account has an outstanding balance. We cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

Signature: ______________________ Date: ______________________