

Patient Registration Form

Account Number: _____ **Medical Record Number:** _____ **Patient:** _____

PLEASE MAKE CORRECTIONS BELOW

Patient Name: _____ Sex: Male Female
 Patient Date of Birth: _____ Marital Status: Married Single Divorced
 Patient SSN: _____
 Address: _____
 City, State, Zip: _____
 Home Phone Number: _____ Cell Phone: _____
 Patient's Employer: _____
 PCP: _____
 Referring Provider: _____
 Emergency Contact: _____ Phone: _____
 Relationship: _____ Address, City, State, Zip Code: _____

Policy Holder Name: _____ Policy Holder Relationship to Patient: _____
 Policy Holder Address: _____ City: _____ State: _____ Zip code: _____
 Policy Holder Birthday: _____ Phone: _____
 Policy Holders Employer: _____ Policy holder Retired? Yes No

Primary Insurance:	Copayment: _____	Secondary Insurance:
Name: _____		Name: _____
Address: _____		Address: _____
City, State, Zip: _____		City, State, Zip: _____
Policy : _____		Policy : _____
Group Number: _____		Group Number: _____

ASSIGNMENT AND RELEASE:

I hereby assign my insurance benefits to be paid directly to the physician when applicable. I understand that I am financially responsible for any non-covered services. I also authorize the physician to release any information required to process this claim. I further understand any collection fees will also be my responsibility. I realize that if I don't show up for my appointment I may be charged a \$25 fee that I will be responsible to pay.

SIGNED: _____ DATE: _____