

REGISTRATION INFORMATION

Date: _____ (PLEASE PRINT) Home Phone: (____) _____

Patient: _____ Cell Phone: (____) _____
Last Name First Name Middle Initial

Responsible Party (if a minor): _____

Street Address: _____ E-mail: _____

City: _____ State: _____ Zip: _____

Sex: M F Age: _____ Birthdate: _____ Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Patient Employer/School: _____

Employer/School Address: _____

Occupation: _____ Employer/School Phone: (____) _____

Spouse (or responsible party) Employed by: _____

Business Address: _____

Occupation: _____ Business Phone: (____) _____

Purpose of Visit: _____

Who is responsible for this account? _____ Relationship to Patient: _____

Social Security # _____ Spouse's Social Security # _____

Do you have Medical Insurance? No Yes ► If yes,
Name of Primary Insurer: _____
Contract # _____ Group # _____ Subscriber # _____

Name of Secondary Insurer (if any): _____
Contract # _____ Group # _____ Subscriber # _____

Medicare Medicaid Claim ID # _____

If Welfare, your number: _____ County of: _____

I prefer to: Pay my balance in full at time of service. Pay my balance in full upon receipt of first statement.
 Make payment arrangements prior to services being rendered.

In case of emergency, who should be notified? _____ Phone: (____) _____

Your Drugstore Name: _____ Phone: (____) _____

How did you learn of our practice? _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient