

PATIENT REGISTRATION INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____
Last Name First Name Initial

Address _____ Home Phone _____

City _____ State _____ Zip _____

Sex: M F Minor Single Married Long Term Partner Divorced Widowed Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who referred you to our office? _____

In case of emergency, whom should we contact? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D.# _____ Group # _____

ADDITIONAL INSURANCE (IF APPLICABLE)

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D.# _____ Group# _____

ASSIGNMENT AND RELEASE

AUTHORIZATION

I UNDERSTAND AND AGREE THAT, (REGARDLESS OF MY INSURANCE STATUS) I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I HAVE COMPLETED THE ABOVE INFORMATION. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY HEALTH STATUS OR THE ABOVE INFORMATION. I ALSO GIVE PERMISSION TO RELEASE MY RECORDS TO ANY PARTY INVOLVED IN MY HEALTHCARE.

SIGNATURE _____ DATE _____

PARENT SIGNATURE (if patient is a minor) _____ DATE _____