Patient Registration

Patient Information

Name:

Name you prefer to be called:

Date of Birth:

Social Security Number:

Mailing Address:

City, State, Zip:

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Home Phone #:

Cell Phone #:

Work Phone #:

Ext:

Email Address:

How did you hear about us?

Primary Care Physician

Physician's Name:

Mailing Address:

City, State, Zip:

Clinic/Facility Name:

Phone #:

Fax #:

Insurance Information

Primary Insurance:

Subscriber's Name:

Subscriber's Date of Birth:

Policy/ID #:

Relationship to Subscriber:

☐ Self ☐ Spouse ☐ Dependant ☐ Other

Subscriber's Employer:

Employer's Address:

City, State, Zip:

Employer's Phone #:

Secondary Insurance:

Subscriber's Name:

Subscriber's Date of Birth:

Policy/ID #:

Relationship to Subscriber:

☐ Self ☐ Spouse ☐ Dependant ☐ Other

Subscriber's Employer:

Employer's Address:

City, State, Zip:

Employer's Phone #:

In Case Of Emergency

Please Contact:

Relationship to Patient:

Home Phone #:

Alternate Phone #:

Assignment Of Benefits & HIPAA Release

By signing below, I certify that I, and/or my dependent(s) have insurance coverage with the above-named company(ies) and assign directly to this office 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 doctor 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 payable for related services. This consent will end when my current treatment plan is completed or one year from the signed date below.

Patient/Guardian

Date