

PATIENT REGISTRATION FORM

NAME: _____ BIRTHDATE: _____

Like to be called: _____ SSN: _____

ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: Home () _____ Work () _____

Cell () _____

EMPLOYER: _____

BUSINESS ADDRESS: _____

SPOUSE: _____ SPOUSE EMPLOYER: _____

REFERRED BY: _____ PRIMARY CARE MD _____

*PERSON RESPONSIBLE FOR BILL (IF OTHER THAN ABOVE):

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: () _____

NEAREST RELATIVE TO NOTIFY IN CASE OF AN EMERGENCY:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: () _____

INSURANCE:

1. _____ INSURED ID: _____ GROUP # _____

2. _____ INSURED ID: _____ GROUP # _____

AUTHORIZATIONS:

I HEREBY AUTHORIZE PAYMENTS BY MY INSURANCE CARRIER BE MADE DIRECTLY TO THE PROVIDER OF THESE SERVICES. YES _____ NO _____

I UNDERSTAND I AM RESPONSIBLE FOR ANY PORTION OF THE BILL NOT COVERED BY MY INSURANCE CARRIER. I UNDERSTAND I AM RESPONSIBLE FOR GETTING ANY REQUIRED REFERRALS OR AUTHORIZATIONS FROM MY PRIMARY CARE PHYSICIAN, AS STIPULATED BY MY INSURANCE CARRIER, FOR MY TREATMENT AT THIS OFFICE. YES _____ NO _____

I HEREBY AUTHORIZE RELEASE OF INFORMATION FOR INSURANCE CLAIM PURPOSES THE INFORMATION AUTHORIZED FOR RELEASE MY INCLUDE INFORMATION WHICH MAY BE CONSIDERED A COMMUNICABLE OR VENEREAL DISEASE INCLUDING HEPATITIS, SYPHILLIS, GONNORREA, HIV AND AIDS. YES _____ NO _____

I UNDERSTAND ALL OF THE ABOVE AND HEREBY STATE THE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

DATE: _____ SIGNED: _____

(PATIENT)