2020 PATIENT REGISTRATION

MRN # _____

PATIENT INFORMATION (Please print all information and use Blue or Black ink)

First Name ↑	Middle Initial	Last Name	DOB: Month / Day / Year
Address	City	State	Zip Code
Home Phone Number	Cell Phone Number	Email	
Male / Female / Other	Social Security Number	Race	Preferred Language
Emergency Contact Name	Emergency Contact Phone #		Relationship to Patient
Primary Doctor		Referring Doctor (if different)	

PARENT/GUARDIAN INFORMATION (If patient is a minor, check box for responsible party)

☐ Mother	DOB:	SS #	Phone #
Address	City	State	Zip Code
☐ Father	DOB:	SS #	Phone #
Address	City	State	Zip Code

PRIMARY INSURANCE: *Must be completed in full

Insurance Name		Employer
Address	City / State	Zip Code
Group Number	ID/Policy #	Subscriber Name
Subscriber DOB	Subscriber SS #	Relationship to Patient

SECONDARY INSURANCE: *Must be completed in full

Insurance Name		Employer
Address	City / State	Zip Code
Group Number	ID/Policy #	Subscriber Name
Subscriber DOB	Subscriber SS #	Relationship to Patient

ALL PATIENTS and/or GUARANTOR: I hereby authorize the release of any medical information necessary to process any and all of my claims, or facts concerning the treatment provided. I further authorize my insurance company to pay direct to Provider, the medical benefits otherwise payable to me. I understand that I am financially responsible for those charges not paid by my insurance. A photocopy of this authorization shall be considered as valid as the original. This authorization shall remain in effect until such time as revoked by me. In the case of default payment, I promise to pay any legal interest on the balance due together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Signature of Patient or Guarantor **Date**