Date: _____

PATIENT REGISTRATION

Last Name: _____Middle Initial: _____First Name:__ _____
Referring Physician: _____
Family Physician or Internist: _____

PATIENT INFORMATION

Birthdate (mm/dd/yyyy):_____ Age: _____ Sex: M_____ F_____
Occupation: _____ Retired _____ Student _____ Minor _____
Address: Street_____City_____State_____Zip_____
Cell Phone _____ Home Phone _____
Email Address: _____
Employed By: _____
Marital Status: Married _____ Single _____ Separated _____ Divorced _____ Widowed _____
Spouse's Name: _____
Spouse Employed By: _____ Occupation: _____
Who should we contact in the case of an emergency? _____
Phone #: _____ Relationship:_____ _____

Primary Insurance – Responsible Party

Insured Name _____Birthdate (mm/dd/yyyy):_____
Policy #: _____ Group # _____
Insured Street Address_____City_____State_____Zip_____
Insured Employer _____
Employer Address _____
Patient Relationship to Insured (*Circle*) Self / Spouse / Child

Secondary Insurance – Responsible Party

Insured Name _____Birthdate (mm/dd/yyyy):_____
Policy #: _____ Group # _____
Insured Street Address_____City_____State_____Zip_____
Insured Employer _____
Employer Address _____
Patient Relationship to Insured (*Circle*) Self / Spouse / Child

Provide the following information if visit is an Accident or Worker's Compensation Claim

Auto Accident _____ On the job? _____ Date of Injury _____
Authorization No. _____ Referring Doctor _____
Adjuster _____ Phone Number_____

I authorize the Attending Physician to release medical information that may be necessary to request reimbursement from insurance companies to whom I have submitted a claim. I understand I am responsible for all medical fees during my treatment with the Attending Physician.

If surgery is required, I assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, to the Attending Physician.

Signature _____ Print Name _____Date_____