# *PATIENT REGISTRATION FORM*

Patient ______________________________________________
First Name Initial Last Name
Date of birth ____________________ SSN: ____________________
Responsible party ______________________________________
(If patient is under eighteen years of age)
Address ______________________________________________
City ____________________ State ________ Zip Code __________
Phone (Home) ________________ (Cell) ________________
(Work) ________________ May our office call you at work? ________
Marital Status ________________ Spouse's Name ________________
Employer ______________________________________________
Name and address of nearest relative (not living with you) ________________
______________________________________ Phone ________________
Referral Source ______________________________________

*FAMILY MEMBER INFORMATION* (Please list only those family members living in your household)

| | First Name | Last Name | Gender | Relationship | Birth Date |
|---|---|---|---|---|---|
| (1) | | | | | |
| (2) | | | | | |
| (3) | | | | | |
| (4) | | | | | |
| (5) | | | | | |

*PRIMARY MEDICAL INSURANCE INFORMATION*

Subscriber Name ______________________________ SSN ________________
Subscriber's Birth Date ______________________________
Subscriber's Employer ______________________________________
Insurance Company ______________________________________
Policy/ID # ________________________ Group # ________________

**Please sign both blocks:**

**ASSIGNMENT OF BENEFITS**

I authorize payment of medical benefits to myself or the named provider for professional services rendered.

Signed ______________________ Date ________
(Subscriber)

**RELEASE OF INFORMATION**

I authorize the release of any medical information necessary to process this claim.

Signed ______________________ Date ________
(Patient, or parent if Minor)