

PATIENT REGISTRATION FORM

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PATIENT INFORMATION

Date _____ Home Phone _____
Name _____ Soc. Sec. No. _____
Last Name First Name Initial
Address _____
City _____ State _____ Zip _____
Sex M F Age _____ Birthday _____ Single Married Widowed Separated Divorced
Patient Employed By _____ Occupation _____
Business Address _____ Business Phone _____
In case of emergency who should we notify? _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial
Relation to Patient _____ Birthdate _____ Soc. Sec. No. _____
Address (if different from patient) _____ Phone _____
City _____ State _____ Zip _____
Person Responsible Employed By _____ Occupation _____
Business Address _____ Business Phone _____
Insurance Company _____
Contract No. _____ Group No. _____ Subscriber No. _____
Name of Other Dependents Covered Under this Plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? M F
Subscriber Name _____ Relation to Patient _____ Birthdate _____
Address (if different from patient) _____ Phone _____
City _____ State _____ Zip _____
Subscriber Employed By _____ Business Phone _____
Insurance Company _____ Soc. Sec. No. _____
Contract No. _____ Group No. _____ Subscriber No. _____
Name of Other Dependents Covered Under this Plan _____

ASSIGNMENT/RELEASE AND CONSENT TO TREAT

I, the undersigned assign all insurance benefits to _____ if any, otherwise payable to me for services rendered. Understand that I am financially responsible for all charges weather or not paid by insurance, I hereby authorize the named doctor to release all information necessary to secure the payment of benefits, I authorize the use of my signature on all insurance submissions. I am also herby providing consent for treatment.

Responsible Party Signature

Relationship

Date