2019 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 along with a photo copy of the insurance card.

Insurance Name | Payer ID #

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 along with a photo copy of the insurance card.

Insurance Name | Payer ID #

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**