PATIENT REGISTRATION

PERSONAL INFORMATION

Patient Name: (Last) ___________________________ (First) _______________________ (Middle) ______________________

Address: (Street) ______________________________ City/State) ___________________ (Zip) ________________________

Home Phone: ______________________ Business Phone: ____________________ Cell Phone: _________ Email: _________

Birth Date: ________________ Age: ______ Sex: Male_________ Female_________ Social Security#: ________________

Marital Status: **S M D W** Spouses Name: ______________________ Spouses Alternate Phone: _____________________

Emergency Contact: (Other than spouse) __________________________ Phone: _______________ Relationship: _________

Referring Physician: ____ Phone: __________________

How did you hear about our office? Physician________ Patient________ Advertisement _______ Ins Co. ____

INSURANCE INFORMATION

Primary Insurance Company Information (Name, address, and phone number of person responsible for payment)

Subscriber: ____ Date of Birth: __________________________

Social Security#: _____________________________________ Relationship to Patient: _______________________________

Address: (street, city, state) ____ Phone: _____________________________

Employer: ____

Employer Address: (street, city, state, zip) _______________________________ Phone: _____________________________

Insurance Company Name: ____ Phone: _____________________________

Insurance Company Address: (street, city, state, zip) ____

Policy/ID#: _________________________________ Group#: ____________________________ Plan Name: ______________

Secondary Insurance Company Information (Name, address, and phone number of person responsible for payment)

Subscriber: ____ Date of Birth: _________________________________

Social Security #: ____ Relation to Patient: ____________________________

Address: (street, city, state) ____ Phone: ________________________

Employer: ____

Employer Address: (street, city, state, zip) ______________________________________ Phone: _______________________

Insurance Company Name: ____ Phone: _______________________

Insurance Company Address: (street, city, state, zip) ____

Policy/ID#: _________________________________ Group#: __________________________ Plan Name: ________________

RELEASE OF INFORMATION: I authorize the release of all information necessary to process my insurance claims and pertinent to my medical care. This release will remain in effect until revoked by me in writing. A photocopy of this release is to be considered as valid as the original.

Signature: ____ Date: ____