# Patient Registration Form

(All information **MUST** be completed in order to bill your insurance company)

Patient Last Name_____First_____MI_____

Date of Birth_____Patient Social Security_____

Street Address_____Apt #_____

City_____State_____Zip_____-_____

Phone-Home_____Work_____Cell_____

Marital Status (circle one) Married Single Divorced Widowed Separated

Sex (circle one) male female

Employer_____

Person to Notify in an Emergency_____

Phone_____

Referring Physician_____Phone#_____

Address_____fax_____

Primary Insurance Company (Please Provide Copy of Card)_____

Subscriber (if other than patient)

Last Name_____First Name_____MI____

Subscriber's Birthdate_____

Subsciber's Employer_____

Subscriber's Identification Number_____

Group Number_____

Relationship to Patient_____

Secondary Insurance Company (Please Provide Copy of Card)_____

Subscriber Last Name_____First Name_____MI____

Subscriber's Birthdate_____

Subscriber's Identification Number_____

Group Number_____

Relationship to Patient_____

I understand that I am liable for expenses incurred which are not covered under my plan. I understand that all co-payments, deductibles and/or non covered services are to paid in full at the time of service. I hereby authorize the release of any information to my insurance company necessary to process claims. I hereby authorize my insurance company to make payments directly to the physician. I have read and agree to the policies and will abide by them.

Signed_____ Date_____

Print Name_____