DATE ______________________

PATIENT REGISTRATION

FOR INTERNAL USE ONLY
PATIENT NUMBER ____________

PATIENT INFORMATION

SOCIAL SECURITY # ______________________________

FIRST NAME ____________________ MIDDLE ________

LAST NAME ______________________________

SEX ______ DATE OF BIRTH _____/_____/_____

MARITAL STATUS ☐ MARRIED ☐ SINGLE

☐ DIVORCED ☐ WIDOWED

(CHECK ONE) ☐ EMPLOYED ☐ RETIRED ☐ FULL TIME STUDENT

☐ OTHER ______________________________

EMPLOYER ______________________________

EMPLOYER PHONE______________________________

HOME ADDRESS ______________________________

____

CITY ____________________ STATE ______ ZIP _______

EMAIL ______________________________

HOME PHONE (____) ______________________________

WORK PHONE (____) ______________________________

REFERRING PHYSICIAN ______________________________

PRIMARY CARE PHYSICIAN ______________________________

HOW DID YOU HEAR OF US? ______________________________

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other ______________________________

INSURANCE COMPANY ______________________________

INSURED / CARD HOLDER'S NAME ______________________________ RELATIONSHIP ____________________

POLICY # ____________________ GROUP # ____________________ PHONE (____) ____________________

SECONDARY INFORMATION

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other ______________________________

INSURANCE COMPANY ______________________________ SS# ____________________

INSURED / CARD HOLDER'S NAME ______________________________ RELATIONSHIP ____________________

POLICY # ____________________ GROUP # ____________________ PHONE (____) ____________________

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY # ______________________________

RELATIONSHIP ______________________________

FIRST NAME ____________________ MIDDLE ________

LAST NAME ______________________________

ADDRESS ______________________________

SEX ______ DATE OF BIRTH ___ _____/_______/_______

DAYTIME PHONE (____) ______________________________

EMPLOYER ______________________________

ADDRESS ______________________________

CITY ____________________ STATE ______ ZIP _______

WORKERS' COMPENSATION INFORMATION

COMPANY NAME ______________________________

SUPERVISOR'S NAME ______________________________

COMPANY PHONE (____) ______________________________

SUPERVISOR'S PHONE (____) ______________________________

EMERGENCY CONTACT

FIRST NAME ____________________ MIDDLE ________ SEX _____ HOME PHONE (____) ____________________

LAST NAME ______________________________ WORK PHONE (____) ____________________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

____
SIGNATURE (Patient or Parent if Minor) DATE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

____
SIGNATURE (Patient or Parent if Minor) DATE