REGISTRATION SUMMARY

(Please note the information being requested is for the PATIENT)

Patient Information

Patient Name: _______________________________________ Sex: M F DOB: _____________ Age:____

Home Phone: (_____) _____-_________ Cell Phone (_____) ______-________

Home Address: ______________________________________ Last 4 digits of Social Security # ________

City: ______________________ State: ________ Zip: ________ Marital Status: S M W D

Email address: ____ Race: _____Ethnicity: ___________

Responsible Party Information (Must be completed for minor)

Responsible Party Name: ______________________________ Sex: M F DOB: ________________

Relationship to the patient: ________________ Last 4 digits of Social Security # ________

Billing Address: _______________________________________ Phone:(____) _______ -____________

City: _____________________State:________Zip:__________

Employer's Name: ____Phone# ____________________

PRIMARY INSURANCE INFORMATION

Subscriber Name: ____________________________________ Sex: M F DOB: ___________________

Relationship to patient: ____________________________ Last 4 digits of Social security # _________

Insurance Name: _________________________________ Policy # _____________________________

Claims Address: __________________________________ Group # _____________________________

City: ___________________ State:_________ Zip:____________ Phone# (____) _____-__________

SECONDARY INSURANCE INFORMATION:

Subscriber Name: ____________________________________ Sex: M F DOB: ___________________

Relationship to patient: ____________________________ Last 4 digits of Social security # _________

Insurance Name: _________________________________ Policy # _____________________________

Claims Address: __________________________________ Group # _____________________________

City: ___________________ State:_________ Zip:____________ Phone# (____) _____-__________

PLEASE TURN OVER ………………..

EMERGENCY CONTACT: ____ Tel# _____________________

Name of attorney representing you: ____

Name of Primary Care Physician: ____

Name of Referring Physician: ____

Please complete if your visit today is a result of an accident. Type of Accident:

[ ] Auto Accident [ ] Slip and Fall Accident [ ] Workers Comp Accident [ ] Sports Related Accident

If Sports Related Accident, name of school you attend: ____

Date of Accident: ______/______/_______ Location of Accident: (City/State) _____________________

( ) I authorize the release of any information required in the processing of my health claims

( ) I authorize my insurance benefits to be paid directly to the health care provider

____ _______/______/______

Patient/Guardian Signature Date