REGISTRATION FORM

– Patient Information –

(PLEASE PRINT)

Date_____ Home Phone ( ) _____

Name _____ Cell Phone ( ) _____
Last Name First Name Middle Initial

Address_____ SS/HIC/Patient ID # _____

City_____ State_____ Zip_____

Sex ☐M ☐F Age_____ Birthdate_____ ☐Married ☐Widowed ☐Single ☐Minor ☐Separated ☐Divorced ☐Partnered for _____ years

Patient Employer/School_____ Occupation_____

Employer/School Address_____ Employer/School Phone ( ) _____

Whom may we thank for referring you?_____

In case of emergency who should be notified?_____ Phone ( ) _____

– Primary Insurance –

Personal Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient_____ Birthdate _____ Soc. Sec. #_____

Address (if different from patient's)_____ Phone ( ) _____

City_____ State_____ Zip_____

Person Responsible Employed by_____ Occupation _____

Business Address_____ Business Phone ( ) _____

Insurance Company_____

Contract #_____ Group #_____ Subscriber #_____

Names of other dependents covered under this plan_____

– Additional Insurance –

Is patient covered by additional insurance: ☐Yes ☐No

Subscriber Name_____ Relation to Patient _____ Birthdate_____

Address (if different from patient's)_____ Phone ( ) _____

City_____ State_____ Zip_____

Subscriber Employed by_____ Business Phone ( ) _____

Business Address_____ Business Phone ( ) _____

Insurance Company_____ Soc. Sec. #_____

Contract #_____ Group #_____ Subscriber #_____

Names of other dependents covered under this plan_____

–Assignment and Release –

I certify that I, and/or my dependent(s), have insurance coverage with _____ and
Name of Insurance Company(ies)
assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to patient