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PATIENT REGISTRATION FORM

(Please Print)

Patient: ______________________ Birthdate: ______________________
Address: ______________________ S.S No: ______________________
______________________ Home Phone: ______________________
______________________ Cell Phone: ______________________
Email: ______________________
Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/er: ☐

PERSON RESPONSIBLE FOR BILL OR PRIMARY IN THE INSURANCE:

Name: ______________________ S.S. No.______________________
Address: ______________________ Relationship: ______________________
Date of Birth: ______________________ Phone: ______________________

EMPLOYER

Patient Employed by:______________________
Address: ______________________ Phone: ______________________
Spouse Employed By: ______________________
Address:______________________ Phone:______________________

EMERGENCY CONTACT

Name: ______________________ Home Phone: ______________________
Address: ______________________ Work Phone: ______________________
Relationship to You: ______________________ Cell Phone:______________________

PRIMARY INSURANCE

Company ______________________
Address: ______________________
____
Group # ______________________
ID Policy # ______________________

SECONDARY INSURANCE

Company ______________________
Address ______________________
____
Group #______________________
ID Policy # ______________________

Due to the increased cost of mailing statements, and to help keep our fees as low as possible,
we find it necessary to expect our patients to pay their co-pay or non-insurance expenses at the time of service.
If you need to cancel an appointment, please notify the office at least 1 day in advance of the appointment.

FINANCIAL

I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits.
Signed: ______________________ Date: ______________________
(Patient or Parent if Minor)

ASSIGNMENT OF BENEFITS:
I authorize payment of medical benefits to myself or the names provided for professional services rendered.
Signed: ______________________ Date: ______________________

Release of Information:
I authorize the release of any medical information necessary to process this claim or as required by law.
Signed: ______________________ Date: ______________________

HIPAA:
I have reviewed the office record policy and had my questions answered
Signed: ______________________ Date: ______________________

Thank You for Choosing Our Office!