

# Patient Registration Form

## PATIENT INFORMATION *(please print)*

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Billing Address (if different) \_\_\_\_\_  
Work Address (if different) \_\_\_\_\_  
Home Phone \_\_\_\_\_ E-mail Address \_\_\_\_\_  
Work Phone \_\_\_\_\_ Fax \_\_\_\_\_ Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Sec. # \_\_\_\_\_ Sex  M  F  
Driver's License Number: \_\_\_\_\_ State Issued: \_\_\_\_\_  
Marital Status  S  M  D  W  Other \_\_\_\_\_ How did you hear about us? \_\_\_\_\_  
Referring Provider \_\_\_\_\_ Primary Care Provider \_\_\_\_\_  
Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_  
Responsible Party Last Name (if applicable) \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_  
Emergency contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Pharmacy \_\_\_\_\_ Street Address \_\_\_\_\_ City \_\_\_\_\_

## INSURANCE INFORMATION

**Primary Insurance** \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_  
Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
Policy I.D. \_\_\_\_\_ Group # \_\_\_\_\_ Member # \_\_\_\_\_  
Co-pay Amount \_\_\_\_\_ Policy Effective Dates: From: \_\_\_\_\_ To: \_\_\_\_\_  
Patient Relation to Policy Holder:  Self  Spouse  Child  \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_  
Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
Policy I.D. \_\_\_\_\_ Group # \_\_\_\_\_ Member # \_\_\_\_\_  
Policy Effective Dates: From: \_\_\_\_\_ To: \_\_\_\_\_  
Patient Relation to Policy Holder:  Self  Spouse  Child  \_\_\_\_\_

## BILLING INFORMATION

All professional services rendered are the responsibility of the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. If it is necessary to turn this service over to collection for non-payment after 90 days, then the patient is responsible for the bill, the interest, and collection and attorney fees.

### AUTHORIZATION TO PAY BENEFITS TO PROVIDER:

I hereby authorize payment directly to the undersigned Provider for my charges.

### AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the undersigned Provider to release any information acquired in the course of my examination or treatment to my insurance company in writing or by fax.

Signature (Patient or Parent of Minor): \_\_\_\_\_

Date: \_\_\_\_\_