REGISTRATION FORM

Patient Information

Patient Name: _____ DOB: _____ Sex: Female Male
SSN: _____ Home Phone: _____
Address: _____ City/State: _____ ZIP: _____
Employer: _____ Work Phone: _____

Emergency Contact Information

Marital Status: Single Married Divorced

Responsible Party: _____ SSN: _____
Address: _____ City/State: _____ ZIP: _____
Phone: _____ Work Phone: _____

Insurance

Insurance #1: _____
Policy holder name: _____ Relationship: _____
Policy Holder DOB: _____ Policy #:_____ Group #_____
Employer: _____

Insurance #2_____
Policy holder's name: _____ Relationship: _____
Policy Holder DOB: _____Policy #: _____Group #: _____
Employer: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Primary Phone: _____

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD FOR PHOTOCOPY)

I authorize the release of any medical information necessary to process my medical service claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize the physician's billing company to file for benefits on my behalf for medical services rendered. Insurance payments shall be made directly to the physician. If I have Medicare insurance, I authorize the physician to release to the Social Security and Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I certify that I am financially responsible for all services not paid by insurance. This authorization is valid indefinitely until revoked by myself of by the physician by written request.

_____ _____

Patient/Guardian Signature *Date*