PATIENT REGISTRATION

PATIENT SHOULD COMPLETE WHITE AREAS ONLY

PATIENT INFORMATION

PATIENT NUMBER							
LAST NAME		FIRST NAME & INITIAL					
RESIDENCE ADDRESS							
CITY		STATE		ZIP		HOME PHONE	
MAILING ADDRESS							
CITY		STATE		ZIP		HOME PHONE	
DATE OF BIRTH		SEX		MARITAL STATUS (M/S/D)		REFERRED BY	
CELL PHONE		LOCAL PHONE					
EMAIL ADDRESS							
ALLERGIES, IF ANY							
PATIENT SOCIAL SEC #							
PATIENT'S EMPLOYER							
EMPLOYER ADDRESS							
CITY		STATE		ZIP			
EMPLOYER PHONE		EXT.					

GUARANTOR

RESPONSIBLE PARTY LAST NAME		FIRST NAME & INITIAL		RELATIONSHIP			
ADDRESS							
CITY		STATE		ZIP		PHONE	
RESPONSIBLE PARTY DATE OF BIRTH		RESPONSIBLE PARTY S.S. NO.					
RESPONSIBLE PARTY EMPLOYER							
EMPLOYER ADDRESS		EMPLOYER PHONE					

INSURANCE INFORMATION

1

PRIMARY INSURANCE OR MEDICARE NAME					
MEDICARE OR INSURANCE #1 ADDRESS		MED. OR INS. #1 PHONE			
POLICY HOLDER LAST NAME		FIRST NAME		RELATIONSHIP	
CERTIFICATE NO.		GROUP NO.		MEMBER NO.	

2

INSURANCE #2 NAME					
INSURANCE #2 ADDRESS		INS. #2 PHONE			
POLICYHOLDER LAST NAME		FIRST NAME		RELATIONSHIP	
CERTIFICATE NO.		GROUP NO.		MEMBER NO.	

EMERGENCY CONTACT INFORMATION

3

EMERGENCY CONTACT	
RELATIVE / FRIEND PHONE	
SPOUSE'S NAME	
SPOUSE'S WORK PHONE	
SPOUSE'S CELL PHONE	

SIGNATURE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.	SIGNATURE (Patient or Parent if minor)	DATE
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing that I am responsible to pay non-covered services.	SIGNATURE	DATE