Patient Registration

Referred to our office by: _____ Patient Account #: _____
(Office use only)

Patient Name: _____
(Last Name) (First Name) (Middle Initial)

Patient Soc Sec #: _____ Patient Date of Birth: _____ Age: _____

Patient Gender: M / F Patient Marital Status: __S __M __D __W Patient Preferred language: _____

Patient Race: _____ Patient Ethnicity: _____

Patient Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Alternate #: _____ Cell___ Work __

Email address: _____

Insurance Information

(Please provide information for the insured/person who provides the coverage **Please have cards ready to scan)

Name of **Primary** Insurance: _____ Policy / ID #: _____

Group # (if any): _____ **Policyholder's Employer**: _____

Name of Policyholder: _____ Policyholder's DOB: _____

Policyholder's SS #: _____ Relationship to patient: _____

Name of **Secondary** Insurance: _____ Policy / ID #: _____

Group # (if any): _____ Policyholder's Employer: _____

Name of Policyholder: _____ Policyholder's DOB: _____

Policyholder's SS#: _____ Relationship to patient: _____

Emergency Contact

Name: _____ Phone #: _____ Relationship: _____

Insurance Assignment / Billing policy of the office

I hereby authorize payment directly to the physician for medical and/or surgical benefits. I acknowledge that if this office is non-participating with my insurance, that I am responsible for payment on the date of service. I understand that I am responsible for any amount not covered by insurance including co-pays, deductible or co-insurance set forth by my insurance company. I understand co-pays are due on the date of service. I authorize the physicians of this office to release any information in the course of treatment to ONLY my insurance company upon their request. I understand this office will not engage in matters involving third party personal billing resulting in custody, court order or personal circumstances (if patient is a minor). I understand that if my insurance is an HMO, that I must obtain a referral from my primary care physician prior to services being rendered. I fully understand the insurance assignment and billing policies of this office. I certify that all information provided is accurate and correct.

_____ _____
Patient Signature or Legal Guardian if patient is a minor Date of signature