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PATIENT REGISTRATION

PLEASE FILL OUT COMPLETELY

First Name:	MI:	Last:
Street Address:		
City:	State:	Zip:
Email:	Gender: ()M ()F	Home ph: ()
Employer:	Work ph: ()	
Date of Birth: - -	Age:	Alt ph: ()
Employment: ()Employed ()F/T Student ()P/T Student ()Retired ()Other		
Marital Status: ()Single ()Married ()Divorced ()Widowed ()Dependant ()Partnered ()Other		
Responsible Party:	Phone: ()	
Address:	City, ST, ZIP:	
In emergency contact:	Phone: ()	
Referred By:		

PRIMARY INSURANCE

Insurance Company Name:	Phone: ()		
Claims Address:	City, ST, ZIP:		
Subscriber's Name:	Date of Birth: - -	SSN:	
Relationship to you:	()Self ()Spouse ()Dependant ()Other		
Subscribers Address:	City, ST, ZIP:		
I.D. # as shown on card:	Group #:		
Employer of insured:	Phone: ()		

SECONDARY INSURANCE

Insurance Company Name:	Phone: ()		
Claims Address:	City, ST, ZIP:		
Subscriber's Name:	Date of Birth: - -	SSN:	
Relationship to you:	()Self ()Spouse ()Dependant ()Other		
Subscribers Address:	City, ST, ZIP:		
I.D. # as shown on card:	Group #:		
Employer of insured:	Phone: ()		

I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assessed a fee. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Signature _____ Date _____