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Patient Registration Form

PATIENT INFORMATION

LAST NAME		FIRST NAME		MIDDLE INITIAL
STREET ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE	BUSINESS PHONE	CELL PHONE		
EMPLOYER	EMPLOYER LOCATION	EMPLOYMENT STATUS ◯ Full Time ◯ Part Time ◯ Retired		
BIRTH DATE	AGE	GENDER ◯ Male ◯ Female	SOCIAL SECURITY NO.	
REASON FOR VISIT				
SEND BILL TO: (if different address)		MARITAL STATUS		
		COLLEGE STUDENT STATUS ◯ Full Time ◯ Part Time		
PHARMACY		PHONE		
EMERGENCY CONTACT		PHONE		

PRIMARY INSURANCE INFORMATION

LAST NAME		FIRST NAME		MIDDLE INITIAL
STREET ADDRESS (if different)		CITY	STATE	ZIP CODE
BIRTH DATE OF INSURED	SOCIAL SECURITY NO.	RELATIONSHIP ◯ Self ◯ Spouse ◯ Child		
INSURANCE CO.		INSURANCE PHONE		
FULL INSURANCE CO. ADDRESS				
INSURED'S ID	EFFECTIVE DATE OF POLICY	GROUP NUMBER	CO PAYMENT	

SECONDARY INSURANCE INFORMATION

LAST NAME		FIRST NAME	MIDDLE INITIAL
BIRTH DATE	SOCIAL SECURITY NO.	INSURANCE PHONE	
INSURANCE CO.			
FULL INSURANCE CO. ADDRESS			
INSURED'S ID	EFFECTIVE DATE OF POLICY	GROUP NUMBER	

I hereby assign the policy rights and benefits to the Doctor and authorize direct payment from my Insurance Company for professional services rendered. I understand that failing to provide proper insurance information at the time of my visit may result in my being responsible for the entire charge.

I further authorize the Doctor to release any information concerning my examination or treatment to my insurance company. I agree to be personally responsible for any unpaid balance, deductible or co-payment, and if I receive any payments from my insurance company in error, I will sign them directly over the the Doctor.

Patient Signature

Date