

PATIENT REGISTRATION FORM



What is the name of the provider are seeing: _____

Patient Personal Information

Patients Name: _____ Social Security _____
First MI Last Suffix

Date of Birth: _____ Age: _____ Gender: Male Female Relationship Status: Single Married Divorced Other

Employment/Student Status: Ft Employed PT Employed FT Student PT Student

Employer Name: _____ Referred to this provider by _____
Parents employer if minor child

Patient's Home Address _____
Indicate entire address, including apartment number if applicable or POB City / State / Zip

Patient Contact Information (check all that apply):

Home Phone: _____ OK to Call OK to leave message

Work Phone: _____ OK to Call OK to leave message

Cell Phone: _____ OK to Call OK to leave message

Preferred Email Address: _____

OK to email regarding your appointment(s) OK to email regarding your account and statements

Secondary Email Address: _____

Preferred method of contact: Cell Phone Work Phone Home Phone Email

Patient Insurance Information I am not covered by any insurance, skip to next section

Primary Insurance: _____ Type: HMO PPO Unknown

Policy/Member Number: _____ Group Number: _____

Insurance Plan Toll Free Number: _____

Name of Subscriber: _____ Relation to Patient: _____

Date of Birth: _____ Social Security Number: _____ Employer: _____

Secondary Insurance: _____ Type: HMO PPO Unknown

Policy/Plan Number: _____ Group Number: _____

Insurance Plan Toll Free Number: _____

Name of Subscriber: _____ Relation to Patient: _____

Date of Birth: _____ Social Security Number: _____ Employer: _____

Responsible Party Information - Please note this is not your insurance company

Name of Person responsible for unpaid copayments and/or deductibles? _____

Relation to Patient: _____ Date of Birth: _____ SS # _____

Address, if different from patient: _____

Contact Information: Home: _____ Work _____ Cell _____

Email(s): _____

Authorization, Release and Acknowledgement

I authorize the release of medical information necessary to process this and all claims to my insurance company, including Medicare and Medicaid. I request benefits be made payable to _____. I acknowledge that I am financially responsible for this and all claims whether or not paid or covered by my insurance company or other organization. I also agree that if my account is referred to a third party for 90 days past due, I will be responsible for the collection fee which can range from \$20.00 up to 100% of the unpaid balance, depending on my promptness in paying, once and if account referred to collections.

Signature of Patient (Parent/Guardian if minor child)

Date