

Date: _____

PATIENT REGISTRATION

Last Name: _____ Middle Initial: _____ First Name: _____

Referring Physician: _____

Family Physician or Internist: _____

PATIENT INFORMATION

Birthdate (mm/dd/yyyy): _____ Age: _____ Sex: M _____ F _____

Occupation: _____ Retired _____ Student _____ Minor _____

Address: Street _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

Email Address: _____

Employed By: _____

Marital Status: Married _____ Single _____ Separated _____ Divorced _____ Widowed _____

Spouse's Name: _____

Spouse Employed By: _____ Occupation: _____

Who should we contact in the case of an emergency? _____

Phone #: _____ Relationship: _____

Primary Insurance – Responsible Party

Insured Name _____ Birthdate (mm/dd/yyyy): _____

Policy #: _____ Group # _____

Insured Street Address _____ City _____ State _____ Zip _____

Insured Employer _____

Employer Address _____

Patient Relationship to Insured (*Circle*) Self / Spouse / Child

Secondary Insurance – Responsible Party

Insured Name _____ Birthdate (mm/dd/yyyy): _____

Policy #: _____ Group # _____

Insured Street Address _____ City _____ State _____ Zip _____

Insured Employer _____

Employer Address _____

Patient Relationship to Insured (*Circle*) Self / Spouse / Child

Provide the following information if visit is an Accident or Worker's Compensation Claim

Auto Accident _____ On the job? _____ Date of Injury _____

Authorization No. _____ Referring Doctor _____

Adjuster _____ Phone Number _____

I authorize the Attending Physician to release medical information that may be necessary to request reimbursement from insurance companies to whom I have submitted a claim. I understand I am responsible for all medical fees during my treatment with the Attending Physician.

If surgery is required, I assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, to the Attending Physician.

Signature _____ Print Name _____ Date _____