Patient Registration

Date ____________

Patients Name ___________________________________ Date of Birth ___________ Age _______

Address _______________________________________ City _____________ State ___ Zip ________

Home Phone _____________________________ Social Security Number____________________

Business Phone ____________________________ Cell Phone ____________________________

Emergency Contact ___________________________ Emergency Phone__________________________

If under 18, please list Parent/Guardian name ____

Parent/Guardian Date of Birth ____

Referring Physician ____________________________________

Employer ____

Spouses Name ____

Spouses Employer __________________________________ Phone ____________________________

INSURANCE INFORMATION

****In addition to a copy of your card, please fill out the policyholder's name and date of birth if insurance is under anyone other than the patient. Without this information, we will NOT be able to file an insurance claim for your visit****

Insurance #1 _____________________________________ Policy Holders Name_________________

Policy Holders Date of Birth ___________

ID # ____ Group #____________________________

Insurance #2 _____________________________________ Policy Holders Name_________________

Policy Holders Date of Birth ___________

ID # ____ Group #____________________________

Signed____ Date ________

RELEASE: I authorize the release of my medical information to the insurance company and/or doctor's office. I understand that I am financially responsible for charges not covered by my insurance. If a referral is required and one is not already authorized, or my primary care clinic denies the referral, I will assume responsibility for all denied charges.

Signed____ Date ________