Patient Registration

Patient Information **Date**

Last Name________________________________ Phone#H( )______-__________
First Name____________________Initial_______ W( )______-__________
Address________________________________ Family Doctor______________________
City__________________________________ Address___________________________
State______________Zip_________________ City______________________________
Date of Birth__________________Age_______ Phone# ( )______-__________
SS# ______-______-__________ Sex_______ **Referred by**______________________

Primary Insurance Name__________________________________Group#__________
Address____
City__________________________State_______Zip__________Contract#__________
Insured Name____Policy#__________
Insured Date of Birth___________________Sex_____Relationship to Patient__________
Insured Employer____________________________________Phone# W( )______-______

Secondary Insurance Name________________________________Group#__________
Address____
City__________________________State_______Zip__________Contract#__________
Insured Name____Policy#__________
Insured Date of Birth___________________Sex_____Relationship to Patient__________
Insured Employer____________________________________Phone# W( )______-______

RELEASE OF INFORMATION

EMERGENCY CONTACT PERSON (Not residing with you) ____________________________
Relationship__________________________________Phone#( )______-__________
Relationship__________________________________Phone#( )______-__________

Do we have your permission to: Leave a message on your answering machine? ☐ YES ☐ NO
Call you at work? ☐ YES ☐ NO

I understand that it is customary to pay for medical services, which are not covered by my insurance when services are rendered. If a referral is required and not available, I will be responsible.

My preferred method of payment is (pick one) ___Cash ___Personal Check ___Credit Card

Responsible Party Signature____