PATIENT REGISTRATION FORM

PATIENT

Patient Name:_____

Address: _____

(Street) (City/State/Zip)

Home Phone: (____) _____-_____ Work Phone Number: (____) -_____-_____

Date of Birth: _____/_____/_____ Sex: _____ Marital status (circle one): S M D W

Drivers License Number: _____ Social Security Number: _____-___-_____

Employer Name: _____

Employer Address: _____

(Street) (City/State/Zip)

GUARANTOR (Complete only if different from patient)

Guarantor Name: _____ Social Security Number: _____-____-_____

Relationship to Patient: (please check) ( ) self ( ) spouse, or ( ) parent Date of birth: _____

Address:_____ Phone Number: _____

Employer Name: _____ Employer Phone Number: _____

Employer Address: _____

(Street) (City/State/Zip)

Emergency Contact:

Name: _____Relationship: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

PRIMARY INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____

Addresss: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number: _____-_____-_____ DOB: _____

SECONDARY INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____

Addresss: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number: _____-_____-_____ DOB: _____

THIRD INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____

Addresss: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number: _____-_____-_____ DOB: _____

I request payment of authorized Medicare or any other insurance benefits directly to the physician. I acknowledge that I am financially responsible for any unpaid balances, including services not covered by my insurance carrier.

I authorize the physician to release to Medicare or other insurance carrier any information needed to determine these benefits or benefits for related services.

Signature: _____ Date: _____

Signature of Patient/Guarantor