Patient Registration

Patient Name: (First) _____ (Last) _____ (Middle) _____

Address: (Street Address) _____ (City/State) _____ (Zip) _____

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

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

Social Security Number: _____ – _____ – _____ Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced

Emergency Contact Person: _____ Phone #: _____

Name of Referring Physician: _____ Phone #: _____

Allergies - Please Specify: _____ Rx Plan: _____

Guarantor Information: (person responsible for bill, if other than self:)

Name: _____ Relation: _____

Address: _____ Phone #: _____

Employer Information: _____ Phone #: _____

Employer Address: _____ Occupation: _____

INSURANCE INFORMATION

Please complete all insurance details to insure correct billing information.

1. Insurance Name: _____ Phone #: _____

   Address: (Street) _____ (City, State) _____ (Zip) _____

   Subscriber: _____ Subscriber Birth Date: _____ Relation: _____

   Policy / ID #: _____ Claim #: _____

   Plan # / Group #: _____ Group Name: _____

2. Insurance Name: _____ Phone #: _____

   Address: (Street) _____ (City, State) _____ (Zip) _____

   Subscriber: _____ Relation: _____

   Policy / ID #: _____ Claim #: _____

   Plan # / Group #: _____ Group Name: _____

RELEASE AND ASSIGNMENT:

"I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Blue Shield, HMO plans, and Commercial insurance to _____. I understand that I am financially responsible for all charges whether or not covered by said insurance. I hereby authorize said assignee to release any information necessary to secure payment on my behalf."

Signature: _____ Date: _____