Patient Registration Form

PLEASE PRINT

Last Name:

First Name:

Middle Name:

Sex: Date of Birth:

Social Security No.:

Marital Status:

Address:

City: State: Zip:

E-mail: _____

Home Phone:

Work Phone:

Cell Phone:

Preferred Pharmacy Name/Location & Phone: _____

Patient's Race, Ethnicity & Language: _____

Emergency Contact Information

Name:

Phone:

Patient Employer Information

Name:

Phone:

Guarantor Information (to whom statements are sent)

Name:

Address:

Phone: _____-_____-_____

Other:

Patient Referred by:

Primary Care Physician:

Primary Insurance Information

Insurance Plan Name:

Insurance Phone Number:

Address to Send Claims:

Policy Information

Patient's relationship to policy holder:_____

ID/Certification No.:

Policy/Group No.:

Issue Date: _____

Exp Date:_____

Copay Amount:_____

Employer:_____

Policy Holder

Last Name:

First Name:

Middle Name:

Address:

City: _____ State: Zip:

Social Sec Number: _____-_____-_____

Date of Birth: _____/_____/_____ Sex: **M** or **F**

Secondary Insurance Information

Insurance Plan Name:

Insurance Phone Number: _____-_____

Address to Send Claims:

Policy Information

Patient's relationship to policy holder:_____

ID/Certification No.:

Policy/Group No.:

Issue Date: _____

Exp Date:_____

Copay Amount:_____

Employer:_____

Policy Holder

Last Name:

First Name:

Middle Name:

Address:

City: _____ State: Zip:

Social Sec Number: _____-_____-_____

Date of Birth: _____/_____/_____ Sex: **M** or **F**

ASSIGNMENT AND RELEASE:

- **I give my permission and consent for treatment.**
- **I hereby assign my insurance benefits to be paid directly to the physician.**
- **I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.**
- **I authorize the provider, designated representative, or automated robot to contact me by telephone number provided about appointments, billing, and medical care.**
- **I authorize the physician to release any medical information required to process this claim.**
- **I acknowledge that I have viewed and been offered a copy of the "Notice of Privacy Practices".**
- **I authorize the disclosure of my protected health information to _____.**
- **A fee for no shows may apply.**

Name of Person

Signed_____ **Date:**_____

(Patient/Legal Guardian Signature)