

Patient Registration

Patient's Name _____ Today's Date _____

Home Address _____

City _____ State _____ Zip code _____

Telephone (____) _____ Birth Date _____ SS# _____

Email Address _____

Marital Status: Single Married Divorced Widowed

Employer _____

Employer's Address _____

City _____ State _____ Zip code _____

Employer's Telephone (____) _____

Name of Husband/Wife or Guardian _____

Birth Date _____ SS # _____

Employer _____

Employer's Telephone (____) _____

Referring and/or Primary Care Physician _____

Emergency Contact (Not a relative & not living with you):

_____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____

Primary Insurance Company _____

Secondary Insurance Company _____

1. Our office will file insurance for your charges. You will need to pay any applicable co-pays and deductibles at the time of service. Please remember that you are responsible for all fees, regardless of insurance coverage.
2. I understand that I am responsible for obtaining a referral from my primary care physician as stipulated by MY particular policy/plan.
3. I authorize the release of any medical information necessary to process this claim.
4. I authorize the release of medical and surgical benefits.

Signature

Date