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PATIENT REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Date _____ Home Phone _____

Name _____ Soc. Sec. No. _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthday _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By _____ Occupation _____

Business Address _____ Business Phone _____

In case of emergency who should we notify? _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. No. _____

Address (if different from patient) _____ Phone _____

City _____ State _____ zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract No. _____ Group No. _____ Subscriber No. _____

Name of Other Dependents Covered Under this Plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed By _____ Business Phone _____

Insurance Company _____ Soc. Sec. No. _____

Contract No. _____ Group No. _____ Subscriber No. _____

Name of Other Dependents Covered Under this Plan _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company

and assign all insurance benefits to _____ if any, otherwise payable to me for services rendered.

Understand that I am financially responsible for all charges whether or not paid by insurance . I hereby authorize the named doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date