PATIENT REGISTRATION FORM

DOS:	Appt Time:	Patient ID:

PATIENT INFORMATION

Last Name:	First Name:		Middle:
SSN:	DOB:	Sex:	Marital Status:
Address 1:			
Address 2:			
City:	State:		Zip:
Home:	Work:	Cell:	Email:
Patient Employment Status:			

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:	
Emergency Contact Relationship:	Emergency Contact Phone #:

PRIMARY INSURANCE INFORMATION

Primary Insurance Name:	Policy #:	Group #:
Subscriber Last Name:	First Name:	Middle:
Relationship to Patient:	Subscriber SS#:	DOB:
Subscriber Employer:	Employer Phone #:	

SECONDARY INSURANCE INFORMATION

Primary Insurance Name:	Policy #:	Group #:
Subscriber Last Name:	First Name:	Middle:
Relationship to Patient:	Subscriber SS#:	DOB:
Subscriber Employer:	Employer Phone #:	

AUTHORIZATION AND AGREEMENT

I request that benefits be paid by my insurer or heath plan (including Medicare) directly to

I understand that I will be responsible for any outstanding or unpaid balance on my bill. I certify that the information I have reported with regard to my insurance is correct. I authorize the release of medical or other necessary information for this or any related claim to my insurance carrier, or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration. I permit a copy of this authorization to be used in place of the original. I authorize the release of my radiographs and/or reports as requested orally or in written form by my physician(s) or me. I consent for this procedure to be performed on myself or (minor). I have read and consent to the authorization and assignment stated above.

I authorize release of my medical information to my referring physician via facsimile.

Financial Agreement: I understand that I am responsible for the payment of any sums not covered by my health insurance. I further understand that if I don’t carry health insurance, I am responsible for payment of the full amount. I understand that I am responsible for the payment of this account and hereby assume and guarantee payment of expenses incurred by myself or my descendents. Should legal action be required to secure payment of this account I agree to a reasonable collection expense, all court costs and reasonable attorney’s fees incurred thereby

Signature:________________________________ Date:______________________

DOS:______________________