

Patient Registration Form

All information is strictly confidential

Patient Information

Today's Date:

Patient Name:

Last

First

MI

(Maiden)

Age:

Date of Birth:

SS#:

Home Telephone#:

Cell #:

Patient Address:

City

State

Zip Code

Employer:

Address:

Marital Status:

Husband/SO Name:

Husband/SO SS#:

Date of Birth:

Husband/SO Employer:

Employer Address:

Insurance Policy Holder:

Policy Holder Date of Birth:

Self / Spouse / Other

Policy Holder's Address (if different than above)

City

State

Zip Code

Referred By:

Insurance

Primary Insurance Company:

Phone #

Policy #

Group #

Secondary Insurance Company:

Phone #

Policy #

Group #

Assignment of Benefits (Insurance companies require medical offices to have a current signature on file)

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signed:

Date:

I hereby authorize Dr. Cutney to apply for benefits on my behalf for covered services rendered by him. I request that payment from my insurance company be made directly to Dr. Cutney (or to the party who accepts assignment).

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Signed:

Date: