Patient Registration

(Please Print)

PATIENT INFORMATION:

Please present your insurance card at each visit.

(First Name) (Middle Initial) (Last Name)

(If you have been seen previously under another name, please note the name.)

(Employer Name)

(Street Address)

(Employer Address)

(City, State) (Zip Code)

(Employer City, State) (Zip Code)

(Phone Number) (Marital Status)

(Employer Phone Number)

(Cell Phone Number) (Date of Birth)

(Primary Physician)

(Sex) (Social Security Number)

(Emergency Contact Name)

(Patient's Occupation)

(Emergency Phone Number) (Relationship to Patient)

GUARANTOR INFORMATION: (If guarantor is the same as patient, omit this section.)

(First Name) (Middle Initial) (Last Name)

(Employer Name)

(Street Address)

(Employer Street Address)

(City, State) (Zip Code)

(Employer City, State) (Zip Code)

(Phone Number) (Sex)

(Employer Phone Number)

(Social Security Number) (Date of Birth)

(Cell Phone Number)

SUBSCRIBER INFORMATION: (If subscriber is the same as patient, omit this section.)

(Name of Subscriber / Holder of the Insurance)

(Employer Name)

(Address) (City) (State)

(Employer Street Address)

(Social Security Number) (Date of Birth)

(Employer City, State) (Zip Code)

(Patient's Relationship to the Subscriber) (Sex)

HOW WERE YOU REFERRED TO US?

(Please check how you were referred to our clinic.)

- ❑ Yellow Pages
- ❑ Newspaper
- ❑ Physician
- ❑ Family or Friends
- ❑ Insurance
- ❑ Other
- ❑ Advertising

ADVANCED DIRECTIVE / LIVING WILL

Would you like information regarding Advanced Directives?

- ❑ **Yes**
- ❑ **No**

Please be advised that we will initiate CPR and dial 911 when a patient is in distress.

CONSENT FOR TREATMENT

I hereby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled, including Medicare, private insurance and other health plans, to this practice. I understand it is my responsibility to pay any deductible and/or co-pay amount, and that I am financially responsible for all charges whether or not paid by said insurance. The practice is authorized to use my medical information in its quality assurance and utilization review programs, and may disclose such information for medical research purposes.

Signature ______________________________ Date ______________________________

WHAT IS THE BEST PHONE NUMBER WE CAN USE TO CONTACT YOU? ______________________________