

PATIENT REGISTRATION

Name _____ (nickname) _____
First MI Last if any

DOB _____ Age _____ SSN _____ Marital Status: S M

Address _____ Apt # _____ City _____ State _____ Zip _____

Home phone (_____) _____ Cell phone (_____) _____

Work phone (_____) _____ Please any number you prefer we **NOT** call

Employer _____ Address _____

Referring Physician _____ Phone (_____) _____

Primary Care Physician _____ Phone (_____) _____

Primary Insurance _____ Effective Date _____

ID # _____ Group # _____ Subscriber SSN _____

Subscriber Name _____ Subscriber DOB _____

Claims Address _____

Secondary Insurance _____ Effective Date _____

ID# _____ Group # _____ Subscriber SSN _____

Subscriber Name _____ Subscriber DOB _____

Claims Address _____

Person responsible for the bill other than patient:

Name _____ Relationship _____

Address _____ City/State _____ Zip _____

SSN _____ DOB _____ Home Phone (_____) _____

Employer _____ Work Phone (_____) _____

Emergency Contact:

Name _____ Phone(_____) _____ Relationship _____

I understand that I am responsible for my medical bill. I authorize my physician to bill my insurance company for me with the benefits to be paid directly to the said physician. I authorize the physician and insurance company to exchange information required for processing of claims. I understand that my co-pay, if any is due at the time of service, and that I will be billed for any balance not covered by the insurance.

I authorize the exchange of information between Dr. _____ and my primary physician and/or referring physician, in addition to any other physician(s) or facility whom I may designate.

I certify that the above information is correct to the best of my knowledge.

Signature of patient/Guardian _____ **Date** _____

Initials _____ Initials _____ Initials _____ Initials _____ Initials _____ Initials _____ Initials _____
Date _____ Date _____ Date _____ Date _____ Date _____ Date _____ Date _____