

PATIENT REGISTRATION FORM

(Please present insurance/government issued photo ID card to receptionist)

Sex: _____
Patient Name: _____ Race: _____
(First) (Middle) (Last)
Address: _____
(Street, Route, etc.) (City) (State) (Zip)
Birthdate: _____ Social Sec. No.: _____
(Month) (Day) (Year)
Home Phone: __ (____) _____ Cell No.: _____
Email Address: _____
Employer: _____ Employer phone: __ (____) _____
Name of Referring Doctor: _____ Referring Doctor phone: __ (____) _____
Why are you seeing the doctor today? _____

RESPONSIBLE PARTY NAME AND ADDRESS (if other than patient):

Name: _____ Social Sec. No.: _____
Address: _____
(Street, Route, etc.) (City) (State) (Zip)
Employer: _____ Work Phone: __ (____) _____
Driver's License# _____

INSURANCE INFORMATION

Primary Insurance Name _____	Secondary Insurance Name _____
Insurance Address _____	Insurance Address _____
Policy Holder's Name: _____	Policy Holder's Name: _____
Policy # _____	Policy # _____
Group # _____ SS # _____	Group # _____ SS # _____
Policy Holder D.O.B. _____	Policy Holder D.O.B. _____
Employer Name _____	Employer Name _____
Employer Address _____	Employer Address _____
Employer Phone (____) _____	Employer Phone (____) _____
Relationship of patient to the Policy Holder: _____	Relationship of patient to the Policy Holder: _____

I authorize the release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician.

Please check:

Medicare

Medicaid

Private Insurance

 _____
Patient/Guardian Signature

Date