PATIENT REGISTRATION:
PLEASE PRINT AND FILL OUT COMPLETELY

Today's Date: _____

PATIENT INFORMATION:

Patient Name: _____

Date of Birth: _____ **Social Security #:**_____

Mailing Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Email:** _____

Home Phone #: _____**Work #:** _____**Cell #:**_____

Race: _____**Primary Spoken Language:** _____

Sex: Male Female

Marital Status: Married Single Divorced Widowed

(Circle One): Employed Retired Student Other

Employer Name: _____

EMERGENCY CONTACT:

Name: _____ **Relationship to Contact**_____

Home #: _____ **Work#:** _____ **Cell#:** _____

PHARMACY INFORMATION:

Mail Order Pharmacy: _____**Phone #:** _____

Local Pharmacy: _____**Phone #:** _____

Authorization to pay benefits to physician: I hereby authorize payment directly to the physician of the medical group. If any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services & **I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.**

SIGN HERE →_____

INSURANCE INFORMATION:

PRIMARY INSURANCE: (PLEASE FILL OUT COMPLETELY)

COMPANY: _____

ID/MEMBER #: _____

GROUP #: _____

NAME OF POLICY HOLDER: _____

SSN OF POLICY HOLDER: _____

DOB OF POLICY HOLDER: _____

RELATIONSHIP TO POLICY HOLDER: _____

ADDRESS OF POLICY HOLDER: _____

SECONDARY INSURANCE: (PLEASE FILL OUT COMPLETELY)

COMPANY: _____

ID/MEMBER #: _____

GROUP #: _____

NAME OF POLICY HOLDER: _____

SSN OF POLICY HOLDER: _____

DOB OF POLICY HOLDER: _____

RELATIONSHIP TO POLICY HOLDER: _____

ADDRESS OF POLICY HOLDER: _____

PLEASE PROVIDE CARDS AND PHOTO ID/LICENSE TO THE RECEPTIONIST.

If your insurance requires a referral authorization to a specialist, patient is responsible for obtaining this authorization. If not obtained by appointment, patient will be responsible for out of network charges or may have to reschedule appointment.