PATIENT REGISTRATION FORM

PATIENT _____ Date of Birth _____ S.S. Number _____
First Name M.I. Last Name

Patient address _____

City _____ State _____ Zip Code_____

INSURED/RESPONSIBLE PARTY _____
First Name M.I. Last Name

Address _____

City _____ State _____ Zip Code_____

Phone (Home) _____ (Cell) _____

(Work) _____ May our office call you at work? _____Yes _____No

Marital Status _____ Spouse's name _____

Insured's employer _____

Name of nearest relative (not living with you) _____

Address of nearest relative (not living with you) _____

_____ Phone _____

Who referred you to our office? _____

FAMILY MEMBER INFORMATION (Please list only those family members living in patient household)

First Name Last Name Gender Relationship Date of Birth

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

PRIMARY MEDICAL INSURANCE INFORMATION

Subscriber Name _____ Date of Birth _____ SSN _____

Policy/Identification Number _____ Group Number _____

Subscriber's Employer _____

Insurance Company _____

Please sign and date both blocks below:

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to myself or the named provider for professional services rendered.

Signed _____ Date ____/____/_____

RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process claims for services rendered by the named provider.

Signed _____ Date ____/____/_____