Patient Registration

Name_____ Date_____
Last First MI

Address_____
Street City State Zip Code

Home Phone_____ Work Phone_____ Cell Phone_____

Social Security Number_____ Date of Birth_____

Sex: Female Male Marital Status: Single Married Divorced Widowed

Employer_____ Occupation_____

Employer's Address_____

Referring Physician_____

Insurance Information: (Please give your card to the Receptionist for copying)

Primary insurance:_____ Phone Number:_____

Insurance address:_____

Subscriber name:_____ Subscriber SSN:_____ DOB:_____

ID number:_____ Group number:_____

Patient-to subscriber relationship: Self Spouse Parent Child other:_____

Subscribers employer:_____ Employer phone number:_____

Please tell us how you learned of our practice or whom we can thank:

I was a former patient	Patient recommendation	Name_____
Doctor recommendation	Family or friend recommendation	Name_____
Employer recommendation	Yellow pages	
Web page		

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, and prescriptions. I also authorize payment of medical benefits to the physician. Payment is required for all services at the time they are rendered including any applicable co-payments and deductibles.

By law, we are only permitted to discuss your diagnosis and treatment with you (the patient). In the event that a spouse, family member, or close friend may need this information, please list their name in the space provided below.

Name: _____ Relationship: _____

By listing the individual above, you have given us permission to discuss your medical history and treatment with this person. We cannot disclose any of your private health information to anyone who is not listed on this form.

Patient or Responsible Party Signature:_____ **Date:**_____