

Patient #

PATIENT REGISTRATION FORM

 New Patient
 Information Update

PATIENT INFORMATION

Last Name		First Name		MI	SS #	Sex	Birthdate
Street Address				City, State, Zip			
Home Phone		Other Phone		Work Phone (include extension)			
E-Mail Address 1		E-Mail Address 2		How did you hear about our practice? Referring Physician: _____ Friend/Relative <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other _____			
Employment Status: Full time <input type="checkbox"/> Part time <input type="checkbox"/> Retired <input type="checkbox"/> Self <input type="checkbox"/> Student <input type="checkbox"/>				Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Student Full time <input type="checkbox"/> Part time <input type="checkbox"/> None <input type="checkbox"/>			
Employer Name				Employer Address			
Employer Phone				City, State, Zip			
Living Will? No <input type="checkbox"/> Yes <input type="checkbox"/> Date Signed: ___ / ___ / ___				Maiden Name		Alias/Nickname	
Emergency Contact Name				Emergency Contact Relationship to Patient Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> : _____			
Emergency Contact Home Phone				Address			

GUARANTOR INFORMATION

Last Name		First Name		MI	SS #	Sex	Birthdate
Street Address				City, State, Zip			
Home Phone		Other Phone		Work Phone (include extension)			
E-Mail Address 1		E-Mail Address 2		Employment Status: Full time <input type="checkbox"/> Part time <input type="checkbox"/> Retired <input type="checkbox"/> Self <input type="checkbox"/> Student <input type="checkbox"/>			
Employer Name				Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Student Full time <input type="checkbox"/> Part time <input type="checkbox"/> None <input type="checkbox"/>			
Employer Address				City, State, Zip Code, Country			

PRIMARY INSURANCE INFORMATION

Insurance Company		Claims Address					
Member #		Group # or Name					
Copay Amount	Deductible	Effective Date					
Subscriber is: Patient <input type="checkbox"/> Guarantor <input type="checkbox"/> Other <input type="checkbox"/> If other, please complete the rest of this section							
Subscriber Last Name		Subscriber First Name		MI	Subscriber E-Mail Address		
Street Address		City, State, Zip				Phone #	

SECONDARY INSURANCE INFORMATION

Insurance Company		Claims Address					
Member #		Group # or Name					
Effective Date							
Subscriber is: Patient <input type="checkbox"/> Guarantor <input type="checkbox"/> Other <input type="checkbox"/> If other, please complete the rest of this section							
Subscriber Last Name		Subscriber First Name		MI	Subscriber E-Mail Address		
Street Address		City, State, Zip				Phone #	

SIGNATURE

Payment Policy: All services rendered are charged to the patient. Necessary claim forms will be completed to expedite insurance payments. The patient is responsible for all fees, regardless of insurance coverage. Payment is required at time of service, unless other arrangements have been made. Patients with a copay are required to pay on the date of service. I understand that I am responsible for any amount not covered by insurance. I agree to pay any balance due, in full, within 10 days of the statement, unless other arrangements were made, in advance. If payment is not made in a timely manner and collection action becomes necessary, the signature below shall serve as authorization to release the information necessary to the collection agency selected by the provider(s) who have provided services to me.

Insurance Authorization and Assignment: I hereby authorize the release of any medical or other information (necessary to process a claim) to my insurance carrier. I also request payment of government benefits (if any apply) either to myself or to the party who accepts assignment. Furthermore, I authorize payment of medical benefits directly to the medical provider(s) who have treated me or rendered services or materials.

***Authorization for Release of Information to Email Address (if one is provided above):** We collect email addresses for the purpose of notifying patients of business announcements. We may collect and use personal data for the additional purpose of sending advertisements pertaining to specific medical conditions. We do not disclose your personally identifiable information to any outside businesses or organizations, other than for the purposes mentioned in the paragraph above regarding Insurance Claims.

Signature:

Privacy Statement signed? Yes No

Date Signed: