Patient Registration Form

PLEASE PRINT

Last Name:
First Name:
Middle Name:
Sex: Date of Birth:
Social Security No.:
Marital Status:
Address:
City: State: Zip:
E-mail: _____
Home Phone:
Work Phone:
Cell Phone:
Preferred Pharmacy Name/Location & Phone:
_____
Patient's Race, Ethnicity & Language:
_____

Emergency Contact Information

Name:
Phone:

Employer Information

Name:
Phone:

Guarantor Information (to whom statements are sent)

Name:
Address:

Phone: _____-_____-_____

Other:

Patient Referred by:
Patient PCP:

Primary Insurance Information

Insurance Plan Name:

Insurance Phone Number:

Address to Send Claims:

Policy Information

Patient's relationship to policy holder:_____
ID/Certification No.:
Policy/Group No.:
Issue Date: _____
Exp Date:_____
Copay Amount:_____
Employer:_____

Policy Holder

Last Name:
First Name:
Middle Name:
Address:
City: _____ State: Zip:
Social Sec Number: _____-_____-_____
Date of Birth: _____/_____/_____ Sex: **M** or **F**

Secondary Insurance Information

Insurance Plan Name:

Insurance Phone Number: ( )_____-_____

Address to Send Claims:

Policy Information

Patient's relationship to policy holder:_____
ID/Certification No.:
Policy/Group No.:
Issue Date: _____
Exp Date:_____
Copay Amount:_____
Employer:_____

Policy Holder

Last Name:
First Name:
Middle Name:
Address:
City: _____ State: Zip:
Social Sec Number: _____-_____-_____
Date of Birth: _____/_____/_____ Sex: **M** or **F**

ASSIGNMENT AND RELEASE:

- **I hereby assign my insurance benefits to be paid directly to the physician.**
- **I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.**
- **I authorize the provider or a designated representative to contact me by telephone about appointments, billing, and medical care .**
- **I authorize the physician to release any medical information required to process this claim.**
- **I acknowledge that I have viewed and been offered a copy of the "Notice of Privacy Practices".**
- **I authorize the disclosure of my protected health information to _____.**
  Name of Person
- **A fee for no shows may apply.**

Signed_____ **Date:**_____