DATE

PATIENT REGISTRATION FORM

☐ NEW ☐ CHANGE

PLEASE PRINT CLEARLY

PATIENT ACCOUNT NUMBER

PATIENT INFORMATION

PATIENT NAME (Last, First, MI) (Home Telephone)				PATIENT E-MAIL	
ADDRESS (Street, Apt. No.) (Mobile Phone)				PRIMARY CARE PHYSICIAN (Telephone)	
CITY	STATE	ZIP		EMPLOYER NAME TELEPHONE	
DATE OF BIRTH	SOCIAL SECURITY NUMBER			PATIENT STUDENT STATUS If 19 Years or Older ☐ F - Full Time ☐ P - Part Time ☐ N - Not a Student	
MARITAL STATUS ☐ M - Married ☐ X - Separated ☐ D - Divorced ☐ W - Widowed ☐ S - Single ☐ Partnered	AGE	RACE	ETHNICITY	PERSON TO CONTACT IN CASE OF EMERGENCY	(Telephone)

RESPONSIBLE PARTY FOR BILLING IF DIFFERENT THAN PATIENT

RESPONSIBLE PARTY NAME (Last, First, MI) DATE OF BIRTH				SOCIAL SECURITY NUMBER	PATIENT RELATIONSHIP TO RESPONSIBLE PARTY ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER
RESPONSIBLE PARTY ADDRESS (Street, Apt. No.)				EMPLOYER NAME (Telephone)	
CITY	STATE	ZIP		EMPLOYER ADDRESS	
TELEPHONE (Home)	TELEPHONE (Other)			CITY	STATE ZIP

INSURANCE

PRIMARY INSURANCE CARRIER NAME (Telephone)	POLICY ID NUMBER	GROUP NUMBER
INSURANCE CLAIM CENTER ADDRESS (Street, Suite No.)		
CITY	STATE	ZIP
SECONDARY INSURANCE CARRIER NAME	POLICY ID NUMBER	GROUP NUMBER
INSURANCE CLAIM CENTER ADDRESS (Street, Suite No.)		
CITY	STATE	ZIP

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. **THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.** IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE READ AND SIGN)

I HEREBY AUTHORIZE THE PHYSICIAN TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY EXAM AND TREATMENT I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I AGREE TO PAY ALL BALANCE DUE IN FULL WITHIN TEN DAYS OF STATEMENT, UNLESS ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

I understand that if I DO NOT present ACCURATE information regarding my insurance coverage AT THE TIME OF SERVICE - I will be personally responsible to pay the bill if coverage is denied.

DATE _____ SIGNATURE _____