Patient Registration

Last Name ______ First Name ______ Middle Name ______

Date of Birth ______ Gender ______ Social Security Number ______ Marital Status ______

Street Address ______ City ______ State ______ Zip ______

(Area Code)Home Phone ______ (Area Code) Work Phone ______ (Area Code) Mobile ______

Confidential E-mail Address ______ Preferred Pharmacy ______ Address ______ Phone ______

Guarantor Information

Last Name ______ First Name ______ Middle Name ______

Date of Birth ______ Gender ______ Social Security Number ______ Marital Status ______

Street Address ______ City ______ State ______ Zip ______

(Area Code)Home Phone ______ (Area Code) Work Phone ______ (Area Code) Mobile ______

Confidential E-mail Address ______

Primary Insurance Information

Insurance Company Name ______ Policy Holder ______

Claim Address ______ City ______ State ______ ZipCode ______

Insurance Phone Number ______ ID# ______ Group# ______

Policyholder DOB ______ Soc. Sec. Number ______ Relation to patient ______ Employer ______

Secondary Insurance Information

Insurance Company Name ______________________ Policy Holder ______________________

Claim Address ______________________ City ______ State ______ ZipCode ______

Insurance Phone Number ______________ ID# ______________ Group# ______________

Policyholder DOB ________ Soc. Sec. Number ________ Relation to Patient ________ Employer ________

Emergency Contact

Name ______________ Street Address ______________ City ______ State ______ Zip ______

(Area Code) Phone ______________ Relationship to Patient ______________

Signature of Parent, Guardian or Patient ______________________ Date ______

Payment of Benefits

I direct payment to the undersigned Physician of the Medical and/or Surgical Benefits, if any, otherwise payable to me for his services as described but not to exceed the reasonable and customary charge for those services.

Signature of Insured ______________________ Date ______________

Release of Information

I hereby authorize Physician to release any information acquired in the course of my examination or treatment to Insurance company or other health care providers.

Signature of Insured ______________________ Date ______________