PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient is: ( ) Policy Holder
( ) Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____
Address: _____ Address 2:_____
City, State, Zip: _____ _____ Pager: _____ _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cellular :_____
Birth Date: _____ Soc. Sec. _____ Driver Lic: _____

( ) Responsible Party is also a Policy Holder for Patient ( ) Primary Insurance Policy Holder ( ) Secondary Insurance Policy Holder

Patient Information

Address: _____ Address:_____
City : _____ State/Zip: _____ Pager: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ( ) Male ( ) Female Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed

Birth Date: _____ Age: _____ Soc. Sec. _____ Drivers Lic: _____
E-mail: _____ ( ) I would like to receive correspondences via e-mail.

Employment Status: ( ) Full Time ( ) Part Time ( ) Retired Additional Comments:
Student Status: ( ) Full Time ( ) Part Time
Medicaid ID: _____ Pref. Dentist: _____
Employer ID: _____ Pref. Pharmacy: _____
Carrier ID: _____ Pref. Hyg: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: ( ) Self ( ) Spouse ( ) Child ( ) Other
Insured Soc. Sec. _____ Insured Birth Date: _____

Employer: _____
Address: _____
Address2: _____
City, State, Zip: _____

Ins. Company: _____
Address: _____
Address2: _____
City, State, Zip: _____
Group #: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: ( ) Self ( ) Spouse ( ) Child ( ) Other
Insured Soc. Sec: _____Insured Birth Date: _____

Employer: _____
Address: _____
Address2: _____
City, State, Zip: _____

Ins. Company: _____
Address: _____
Address2: _____
City, State, Zip: _____
Group #: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Who to call for an emergency

Name: _____ Home Phone: _____
Address: _____ Work Phone: _____
Relationship: _____ Cellular: _____

Referred Sources

Referred by:
( ) External Mailer ( ) Doctor's offices ( ) Provider ( ) Internet/Our web site ( ) Friend ( ) Relatives
( ) Other Sources ( ) Not Referred

Name of Source:
_____

I recognize and accept responsibility for payment of services rendered regardless of insurance coverage. This includes, but is not limited to, co-insurance, co-payment, deductible and non-covered services. I authorize payment directly to my physician for any benefits due for the services rendered. I understand that should it become necessary to file suit to recover any uncollected charges, I will be responsible for all court costs, reasonable attorney fees, and interest due.

_____ _____
Signature of Patient (Legal Guardian, if Minor) Date