



PATIENT REGISTRATION

PHYSICIAN BEING SEEN: _____
APPOINTMENT LOCATION: _____
PATIENT NUMBER _____

DATE _____

PATIENT INFORMATION

SOCIAL SECURITY #: _____
FIRST NAME _____ MIDDLE _____
LAST NAME _____
SEX _____ DATE OF BIRTH ____/____/____
 SINGLE MARRIED DIVORCED WIDOWED
 EMPLOYED RETIRED FT STUD OTHER _____
DRIVER'S LICENSE# _____
(PLEASE PROVIDE YOUR CARD TO RECEPTIONIST FOR COPY)
EMPLOYER _____
EMPLOYER ADDRESS _____
STE. _____ CITY _____ STATE _____ ZIP _____
EMPLOYER PHONE (____) _____

PATIENT PRIMARY LANGUAGE _____
HOME ADDRESS _____
APT. _____ CITY _____ STATE _____ ZIP _____
SECONDARY ADDRESS _____
APT. _____ CITY _____ STATE _____ ZIP _____
E-MAIL _____
HOME PHONE (____) _____
WORK PHONE (____) _____ EXT. _____
CELL PHONE (____) _____
REFERRING PHYSICIAN _____ PHONE _____
HOW DID YOU HEAR OF US? _____

INSURANCE INFORMATION PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

Commercial Medicaid Medicare Worker's Compensation Other _____
INSURANCE COMPANY _____ POLICY # _____ GROUP # _____
INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP _____
INSURED D.O.B. ____/____/____ S.S.# _____ PHONE (____) _____
EMPLOYER _____ CITY/STATE _____ EMPLOYER PHONE (____) _____

SECONDARY INSURANCE INFORMATION PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

Commercial Medicaid Medicare Worker's Compensation Other _____
INSURANCE COMPANY _____ POLICY # _____ GROUP # _____
INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP _____
INSURED D.O.B. ____/____/____ S.S.# _____ PHONE (____) _____
EMPLOYER _____ CITY/STATE _____ EMPLOYER PHONE (____) _____

PHARMACY INFORMATION

PHARMACY _____ PHARMACY PHONE (____) _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT

RELATIONSHIP TO PATIENT _____ SEX _____ HOME PHONE (____) _____
FIRST NAME _____ MIDDLE _____ WORK PHONE (____) _____
LAST NAME _____ CELL PHONE (____) _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

SIGNATURE (Patient or Parent if Minor) Date

SIGNATURE Date