

PATIENT REGISTRATION FORM

PATIENT ACCOUNT NUMBER	PRACTICE NAME	DATE

PATIENT INFORMATION *(Please write information about the patient here.)*

PATIENT'S NAME (Last, First, Middle Initial)	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	REFERRING DOCTOR
PATIENT'S ADDRESS	REFERRING DOCTOR ADDRESS CITY STATE ZIP	
CITY STATE ZIP	EMPLOYER'S NAME TELEPHONE ()	
TELEPHONE MARITAL STATUS <input type="checkbox"/> Separated D.O.B. <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	EMPLOYER'S ADDRESS CITY STATE ZIP	
AGE SOCIAL SECURITY NO. DRIVERS LICENSE NO.	EMPLOYMENT STATUS STUDENT STATUS <input type="checkbox"/> Full Time <input type="checkbox"/> Retired <input type="checkbox"/> Full Time <input type="checkbox"/> Not a student <input type="checkbox"/> Part Time <input type="checkbox"/> Not Employed <input type="checkbox"/> Part Time	

INSURANCE INFORMATION *(Please write information about the patient's insurance here.)*

PRIMARY INSURANCE COMPANY NAME <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> W. Comp	SECONDARY INSURANCE COMPANY NAME <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> W. Comp
INSURANCE COMPANY'S ADDRESS	INSURANCE COMPANY'S ADDRESS
CITY STATE ZIP	CITY STATE ZIP
INSURED'S ID NUMBER GROUP PLAN NUMBER	INSURED'S ID NUMBER GROUP PLAN NUMBER

POLICYHOLDER INFORMATION

Complete the information below if the PATIENT is not the POLICYHOLDER

PRIMARY POLICY HOLDER'S NAME (Last, First, M.I.)	D.O.B.
PRIMARY POLICY HOLDER'S ADDRESS	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
CITY STATE ZIP	TELEPHONE ()
EMPLOYER'S NAME OR SCHOOL NAME	TELEPHONE ()
EMPLOYER'S ADDRESS	
CITY STATE ZIP	
SOCIAL SECURITY NO.	RELATIONSHIP TO PATIENT <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> SPOUSE PARENT OTHER
EMPLOYER PLAN COVERAGE <input type="checkbox"/> <input type="checkbox"/> YES NO	IF CHAMPUS: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Deceased Branch of Service:

*Is the secondary policy holder the: Patient
 Primary Policyholder Other
 Complete the information below if you checked "Other"*

SECONDARY POLICYHOLDER'S NAME (Last, First, M.I.)	D.O.B.
SECONDARY POLICY HOLDER'S ADDRESS	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
CITY STATE ZIP	TELEPHONE ()
EMPLOYER'S NAME OR SCHOOL NAME	TELEPHONE ()
EMPLOYER'S ADDRESS	
CITY STATE ZIP	
SOCIAL SECURITY NO.	RELATIONSHIP TO PATIENT <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> SPOUSE PARENT OTHER
EMPLOYER PLAN COVERAGE <input type="checkbox"/> <input type="checkbox"/> YES NO	IF CHAMPUS: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Deceased Branch of Service:

RESPONSIBLE PARTY INFORMATION

Responsible party is: Patient Primary Policyholder Secondary Policyholder

(Please complete the information below if the person responsible for paying is not the PATIENT or the POLICYHOLDER.)

RESPONSIBLE PARTY'S NAME (Last, First, M.I.)		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	SOCIAL SECURITY NO. DRIVERS LICENSE NO.	LEGAL REP <input type="checkbox"/> Yes <input type="checkbox"/> No
RESPONSIBLE PARTY'S ADDRESS		STATE	ZIP	EMPLOYER'S NAME ()
TELEPHONE ()	RELATIONSHIP TO PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN <input type="checkbox"/> OTHER		EMPLOYER'S ADDRESS	STATE ZIP

I AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES SHOWN BELOW. YOU SHOULD READ THOSE TERMS CAREFULLY.

X _____ Date _____
SIGNED (Patient, or parent if under 18 years of age.)

HOW DID YOU HEAR ABOUT US? _____ _____
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IN CASE OF AN EMERGENCY -WHO SHOULD WE CONTACT?- (Please list someone living at a residence other than those listed on the reverse side)	NAME _____ ADDRESS _____ CITY _____ STATE _____	TELEPHONE: Day – _____ Night – _____ RELATIONSHIP _____
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Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including medicare, private insurance and other health plans to the practice named on the other side of this form.

The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

THANK YOU FOR YOUR COOPERATION