

Patient Registration Information

Please PRINT AND complete ALL sections below!

PATIENT'S PERSONAL INFORMATION	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Name: _____ <small>last name first name initial</small>	
Date of Birth: ____ / ____ / ____ Social Security #: ____ - ____ - ____ Cell Phone: (____) _____	
Home Phone: (____) _____ Work Phone: (____) _____	
Address: _____ Apt. #: ____ City: _____ State: ____ Zip: _____	
PATIENT'S / RESPONSIBLE PARTY INFORMATION	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:
Name: _____ <small>last name first name initial</small>	
Date of Birth: ____ / ____ / ____ Social Security #: ____ - ____ - ____ Cell Phone: (____) _____	
Home Phone: (____) _____ Work Phone: (____) _____	
Address: _____ Apt. #: ____ City: _____ State: ____ Zip: _____	
PATIENT'S INSURANCE INFORMATION	Please present insurance cards to receptionist.
PRIMARY Insurance Name: _____	
Address: _____ City: _____ State: ____ Zip: _____ <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Name of insured: _____ Date of Birth: _____ Relationship to insured: _____	
Policy #: _____ Group #: _____ Copay: \$ _____	
SECONDARY Insurance Name: _____	
Address: _____ City: _____ State: ____ Zip: _____ <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Name of insured: _____ Date of Birth: _____ Relationship to insured: _____	
Policy #: _____ Group #: _____ Copay: \$ _____	
Name: _____	
Address: _____ City: _____ State: ____ Zip: _____	
Name: _____	
Address: _____ City: _____ State: ____ Zip: _____	
Name: _____ Relationship: _____	
Address: _____ City: _____ State: ____ Zip: _____	

Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to PRACTICE NAME, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Your Signature: _____