

**PATIENT REGISTRATION**

**PATIENT INFORMATION**

NAME: \_\_\_\_\_ SS#: \_\_\_\_\_  
(LAST) (FIRST) (MI)

ADDRESS: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: M F MARITAL STATUS: CH S M D W

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

If this is a child, please provide the following information for the parent responsible for the bill:

NAME: \_\_\_\_\_ SS#: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\* IF DIFFERENT FROM THE CHILD

HOME PHONE: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

**PRIMARY INSURANCE**

INSURANCE CO: \_\_\_\_\_

CLAIM ADDRESS: \_\_\_\_\_  
IF IT DOES NOT APPEAR ON CARD

POLICY HOLDER: \_\_\_\_\_

SS#: \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

- OFFICE USE ONLY -

Reviewed By: \_\_\_\_\_  
(Name of Front Desk Employee)

**SECONDARY INSURANCE**

INSURANCE CO: \_\_\_\_\_

CLAIM ADDRESS: \_\_\_\_\_  
IF IT DOES NOT APPEAR ON CARD

POLICY HOLDER: \_\_\_\_\_

SS#: \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

- OFFICE USE ONLY -

Reviewed By: \_\_\_\_\_  
(Name of Front Desk Employee)

EMERGENCY CONTACT: \_\_\_\_\_  
(NAME) (RELATIONSHIP) (PHONE #)

FAMILY PHYSICIAN: \_\_\_\_\_ PHONE #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

Did your family physician refer you? Y N If No, please indicate the physician who did: \_\_\_\_\_

If your insurance plan had you select a primary care physician, please indicate who it is: \_\_\_\_\_

PLEASE LIST ANY ALLERGIES THE PATIENT MAY HAVE: \_\_\_\_\_

I authorize the release of any medical information necessary to process my claims.  
I authorize payment of medical benefits directly to the physician for services rendered.  
I understand that I am responsible for all co-payments, coinsurance and services deemed "non-covered" by my insurance.  
I authorize my physician to act as my agent in assisting me to obtain payment from my insurance companies.

\_\_\_\_\_  
(SIGNATURE OF PATIENT)

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(SIGNATURE OF LEGAL GUARDIAN IF PATIENT IS A MINOR)

\_\_\_\_\_  
(DATE)