Patient # [ ]

PATIENT REGISTRATION FORM

☐ New Patient
☐ Information Update

PATIENT INFORMATION

Last Name	First Name	MI	SS #	Sex	Birthdate

Street Address	City, State, Zip
Home Phone / Other Phone	Work Phone (include extension)
E-Mail Address 1 / E-Mail Address 2	How did you hear about our practice? Referring Physician :____ Friend/Relative☐ Yellow Pages ☐ Other ____

Employment Status: Full time☐ Part time ☐ Retired ☐ Self☐ Student☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Widow☐

Student Full time☐ Part time ☐ None☐

Employer Name	Employer Address
Employer Phone	City, State, Zip
Living Will? No ☐ Yes ☐ Date Signed: ___ / ___ / ___	Maiden Name / Alias/Nickname
Emergency Contact Name	Emergency Contact Relationship to Patient: Spouse ☐ Parent ☐ Child ☐ Other☐:____
Emergency Contact Home Phone	Address

GUARANTOR INFORMATION

Last Name	First Name	MI	SS #	Sex	Birthdate

Street Address	City, State, Zip
Home Phone / Other Phone	Work Phone (include extension)
E-Mail Address 1 / E-Mail Address 2	Employment Status: Full time☐ Part time ☐ Retired ☐ Self☐ Student☐
Employer Name	Marital Status: Single ☐ Married ☐ Divorced ☐ Widow☐ / Student Full time☐ Part time ☐ None ☐
Employer Address	City, State, Zip Code, Country

PRIMARY INSURANCE INFORMATION

Insurance Company	Claims Address
Member #	Group # or Name
Copay Amount / Deductible	Effective Date

Subscriber is: Patient ☐ Guarantor ☐ Other ☐ If other, please complete the rest of this section

Subscriber Last Name	Subscriber First Name	MI	Subscriber E-Mail Address
Street Address	City, State, Zip		Phone #

SECONDARY INSURANCE INFORMATION

Insurance Company	Claims Address
Member #	Group # or Name
Effective Date	

Subscriber is: Patient ☐ Guarantor ☐ Other ☐ If other, please complete the rest of this section

Subscriber Last Name	Subscriber First Name	MI	Subscriber E-Mail Address
Street Address	City, State, Zip		Phone #

SIGNATURE

Payment Policy: All services rendered are charged to the patient. Necessary claim forms will be completed to expedite insurance payments. The patient is responsible for all fees, regardless of insurance coverage. Payment is required at time of service, unless other arrangements have been made. **Patients with a copay are required to pay on the date of service.** I understand that I am responsible for any amount not covered by insurance. **I agree to pay any balance due, in full, within 10 days of the statement, unless other arrangements were made, in advance.** If payment is not made in a timely manner and collection action becomes necessary, the signature below shall serve as authorization to release the information necessary to the collection agency selected by the provider(s) who have provided services to me.

Insurance Authorization and Assignment: I hereby authorize the release of any medical or other information (necessary to process a claim) to my insurance carrier. I also request payment of government benefits (if any apply) either to myself or to the party who accepts assignment. Furthermore, I authorize payment of medical benefits directly to the medical provider(s) who have treated me or rendered services or materials.

***Authorization for Release of Information to Email Address (if one is provided above):** We collect email addresses for the purpose of notifying patients of business announcements. We may collect and use personal data for the additional purpose of sending advertisements pertaining to specific medical contitions. We **do not** disclose your personally identifiable information to any outside businesses or organizations, other than for the purposes mentioned in the paragraph above regarding Insurance Claims.

Signature: Privacy Statement signed? Yes ☐ No ☐	Date Signed: