

DATE \_\_\_\_\_

# PATIENT REGISTRATION

FOR INTERNAL USE ONLY  
PATIENT NUMBER \_\_\_\_\_

## PATIENT INFORMATION

SOCIAL SECURITY # \_\_\_\_\_ HOME ADDRESS \_\_\_\_\_

FIRST NAME \_\_\_\_\_ MIDDLE \_\_\_\_\_

LAST NAME \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SEX \_\_\_\_\_ DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_

EMAIL \_\_\_\_\_

MARITAL STATUS  MARRIED  SINGLE

DIVORCED  WIDOWED

(CHECK ONE)  EMPLOYED  RETIRED  FULL TIME STUDENT

OTHER \_\_\_\_\_

EMPLOYER \_\_\_\_\_ HOME PHONE (\_\_\_\_) \_\_\_\_\_

WORK PHONE (\_\_\_\_) \_\_\_\_\_

REFERRING PHYSICIAN \_\_\_\_\_

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 \_\_\_\_\_

INSURED / CARD HOLDER'S NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

Commercial  Medicaid  Medicare  Worker's Compensation  Other \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_

INSURED / CARD HOLDER'S NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

## WORKERS' COMPENSATION INFORMATION

COMPANY NAME \_\_\_\_\_ COMPANY PHONE (\_\_\_\_) \_\_\_\_\_

SUPERVISOR'S NAME \_\_\_\_\_ SUPERVISOR'S PHONE (\_\_\_\_) \_\_\_\_\_

## EMERGENCY CONTACT

SOCIAL SECURITY # \_\_\_\_\_ SEX \_\_\_\_\_

FIRST NAME \_\_\_\_\_ MIDDLE \_\_\_\_\_ HOME PHONE (\_\_\_\_) \_\_\_\_\_

LAST NAME \_\_\_\_\_ WORK PHONE (\_\_\_\_) \_\_\_\_\_

## SPOUSE / GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY # \_\_\_\_\_ SEX \_\_\_\_\_ DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_

RELATIONSHIP \_\_\_\_\_ DAYTIME PHONE (\_\_\_\_) \_\_\_\_\_

FIRST NAME \_\_\_\_\_ MIDDLE \_\_\_\_\_ EMPLOYER \_\_\_\_\_

LAST NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**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.

SIGNATURE (Patient or Parent if Minor) \_\_\_\_\_ DATE \_\_\_\_\_

**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 \_\_\_\_\_ DATE \_\_\_\_\_