Date ______________________ **PLEASE PRINT** Home Phone ______________________

☙ Patient Information ☙

Name ____ SS/HIC/Patient ID ______________

Last Name First Name Middle Initial

Address ____ Cell Phone ______________

City ______________________ State ______________________ Zip ______________

Sex ☐ M ☐ F Age _____ Birthdate ___________ ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _______ years

Patient Employer/School ______________________________ Occupation ______________

Employer/School Address ______________________________ Cell Phone ______________

Who may we thank for referring you? ____

In case of emergency who should be notified? ______________________ Phone ______________

☙ Primary Insurance ☙

Person Responsible for Account ____

Last Name First Name Middle Initial

Relation to Patient ______________ Birthdate ______________ Soc. Sec. # ______________

Address (if different from patient's) ______________________________ Phone ______________

City ______________________ State ______________________ Zip ______________

Person Responsible Employed by ______________________________ Occupation ______________

Business Address ______________________________ Business Phone ______________

Insurance Company ____

Contract # ______________ Group # ______________ Subscriber # ______________

Names of other dependents covered under this plan ____

☙ Additional Insurance ☙

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ______________ Relation to Patient ______________ Birthdate ______________

Address (if different from patient's) ______________________________ Phone ______________

City ______________________ State ______________________ Zip ______________

Subscriber Employed by ______________________________ Soc. Sec. # ______________

Insurance Company ______________________________ Business Phone ______________

Contract # ______________ Group # ______________ Subscriber # ______________

Names of other dependents covered under this plan ____

☙ Assignment and Release ☙

I certify that I, and/or my dependents(s) have insurance coverage with ______________________________ and assign directly to Dr. ______________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above name physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ ______________

Signature of Patient, Parent, Guardian or Personal Representative Date

____ ______________

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

☙ Registration Form ☙