PATIENT REGISTRATION FORM

DATE_______________ PATIENT NUMBER_____________

PATIENT INFORMATION

FIRST NAME_________________________ LAST NAME _________________________Middle_________________

DATE OF BIRTH ____/____/20___ SEX_______ S.S. #____

HOME ADDRESS ____

CITY _________________STATE______________ ZIP CODE __________________PHONE #_____________________

INSURANCE INFORMATION

INSURANCE COMPANY______________________________ POLICY #_____________________________________

GROUP #_________________________ DATE OF BIRTH____/_____/_____ S.S. #___________________________

INSURED/CARD HOLDER'SNAME____

EMERGENCY CONTACT

MOTHER'S NAME____

HOME PH__________________________WK PH_____________________________CELL ____________________

FATHER'S NAME ____

HOME PH__________________________WK PH_____________________________CELL ____________________

RESPONSIBLE PARTY

NAME____

DR. LIC #____S.S. #____

AUTHORIZATON 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 NONECOVERED SERVICES. AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE TO PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY TREATMENT NECESSARY TO PROCESS INSURANCE CLAIMS.

SIGNATURE______________________________________DATE___________________________