

PATIENT REGISTRATION

DATE _____ ACCT.NUMBER _____ PT.NUMBER _____

PATIENT INFORMATION

First Name _____ Middle Name _____ Last Name _____

Birthdate _____ Sex _____ Marital Status _____ Phone No. _____ Cell Phone. _____ E-Mail _____

Patient Address (Street, Route, Apt. No., Etc.) _____ City _____ State _____ Zip Code _____

Drivers License No. _____ Soc. Sec.No. _____ Occupation _____

Employer _____ Employer Phone No. _____

Employer Address _____

Referring Physician _____ Whom to contact in case of Emergency _____ Telephone No. _____

INSURANCE INFORMATION

You are responsible for obtaining a referral if one is required by your insurance carrier. If we are participating providers with your insurance carrier, we will file your claim for your office visit or surgery and allow 45 days for payment in full. Should payment not be received within 45 days, the balance due will become the obligation of the guarantor on the account and must be paid within 30 days. If you don't have insurance or we are not a participating provider with your insurance carrier, payment is expected today for services rendered.

Primary: _____
Insurance company/third party _____ Group or Contract No. _____ Policy holder's name/relationship to patient _____ DOB _____

Policy holder employer _____ Policy holder's address if different from patient _____

Secondary: _____
Insurance company/third party _____ Group or Contact No. _____ Policy holder's name/relationship to patient _____

Is your visit due to a work-related accident? Yes _____ No _____ Date of injury: _____

RESPONSIBLE PARTY

Patient Name: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by provider of service and (or) supplier. I authorize any holder or medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related service. **LIFETIME AUTHORIZATION**

Signature of Patient: _____ Date _____

Responsible Party: _____ Date _____