PATIENT REGISTRATION

PATIENT SHOULD COMPLETE WHITE AREAS ONLY

PATIENT NUMBER			
LAST NAME		FIRST NAME & INITIAL	
ADDRESS LINE 1			
ADDRESS LINE 2			
CITY		STATE		ZIP	
HOME PHONE		CELL PHONE	
DATE OF BIRTH		SEX		MARITAL STATUS		REFERRED BY	
DOCTOR			
PATIENT S.S. NO.			
PATIENT'S EMPLOYER			
EMPLOYER ADDRESS			
CITY		STATE		ZIP	
EMPLOYER PHONE		EXT.		OCCUPATION	

RESPONSIBLE PARTY LAST NAME		FIRST NAME & INITIAL		RELATIONSHIP	
ADDRESS					
CITY		STATE		ZIP		PHONE	
RESPONSIBLE PARTY DATE OF BIRTH		RESPONSIBLE PARTY S.S. NO			
RESPONSIBLE PARTY EMPLOYER					
EMPLOYER		EMPLOYER PHONE			

MEDICARE OR INSURANCE #1 NAME			
MEDICARE OR INSURANCE #1 ADDRESS		MED. OR INS. #1 PHONE	
POLICYHOLDER LAST NAME		FIRST NAME	
CERTIFICATE NO.		GROUP NO.		MEMBER NO.	

INSURANCE #2 NAME			
INSURANCE #2 ADDRESS		MED. OR INS. #2 PHONE	
POLICYHOLDER LAST NAME		FIRST NAME	
CERTIFICATE NO.		GROUP NO.		MEMBER NO.	

INSURANCE #3 NAME			
INSURANCE #3 ADDRESS		MED. OR INS. #3 PHONE	
POLICYHOLDER LAST NAME		FIRST NAME	
CERTIFICATE NO.		GROUP NO.		MEMBER NO.	

SPOUSE'S NAME	SPOUSE'S WORK PHONE	
NEAREST LIVING RELATIVE OR FRIEND NOT LIVING WITH YOU	RELATIVE/FRIEND PHONE	

I have received the HIPPA Policy______________________________Initials

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if an otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services, co-pays, co-insurance or deductibles.

SIGNATURE (Patient or Parent if Minor)

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.

DATE