

Patient Registration Form

Please complete all areas of this form * Indicates areas of information required by our office to facilitate insurance billing

Name: _____
Last First M.I.

Address: _____
Street (or P.O. Box) City State Zip

Home Phone: (____) _____ Work Phone: (____) _____ Other (____) _____

Email address: _____ *Social Security # _____

Birth date: _____ Age: _____ Sex: M F Primary Care Physician: _____ Phone # _____

Marital Status: S M D W P Patient Occupation: _____

*Employer: _____ Employer Address: _____

How you were first referred to our office? Friend: _____ Physician: _____

Web site: ____ Yellow Pages: ____ Print Ad: ____ TV/Radio: ____ Medical Association: ____ other: _____

May we thank the person who referred you to our office? YES NO

Is this a job-related injury? YES NO If yes, date of injury: _____

Medicare Patients only: Supplemental Insurance is provided by: Patient ____ Employer ____

Emergency Contact: _____
Name Phone # Relation to Patient

*Subscriber's Information for Insurance (if other than patient)

*Mr./Ms.: _____
Last First M.I. Relation to Patient

Address: _____
Street (or P.O. Box) City State Zip

Home Phone: (____) _____ Work Phone: (____) _____ * Date of Birth: _____

*Social Security # _____ *Employer: _____

The above information is true to the best of my knowledge. I understand I am responsible for charges associated with medical services and agree to pay all bills within 30 days of receipt of statement, unless other arrangements are made. I authorize the physician and clinic to release any information to process insurance claims and perform internal quality and peer review processes. If my procedure is billed to my insurance I agree to authorize direct payment to the physician. I consent to have medical photographs by the physician.

Patient Signature

Date

For Office Use Only