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Patient Registration

Name: _____
Last First Middle

Social Security Number: _____-____-_____ Sex: ____ Female ____Male

DOB: _____ Age: _____ Marital status:_____ Race:_____

Address: _____

City, State, Zip: _____

Home phone: _____ _____ _____ Work phone: _____ _____ _____

Fax: _____ _____ _____ E-mail: _____

Occupation: _____

Employer: _____ Phone: _____ _____ _____

Primary Insurance: _____
Name Group Number

Co-pay: _____ Referral needed: _____Yes _____No

Secondary Insurance: _____
Name Group Number

Responsible party: _____

Primary Care Doctor (PCD): _____

PCD Phone Number: _____ PCD Email: _____

PCD Address: _____

How did you hear about us?_____

Emergency Information

In case of emergency we would appreciate the name of a contact, NOT living with you at the same address.

Name: _____
Last First Middle

Home phone: _____ _____ _____ Work phone: _____ _____ _____

Please read the following statement carefully before signing

I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize the clinic to recieve all benefits to which my dependents or I are entitled under my health insurance plan. In addition, I will not withhold or delay payment if my insurance company denies payment on any of the charges. I have been informed of the $35.00 fee on checks returned from my bank for insufficient funds. The undersigned agrees that whether s/he signs as an agent, that s/he is obligated to pay for the account. Should the balance of the account exceed an amount the undersigned agrees to pay in full, a payment plan can be established with 1% per month interest on the unpaid balance.

Signature: _____ Date: _____

Please give the receptionist your insurance card.